Guidelines for Implementing the California Children and Families Act

October 2006

The First 5 California Children and Families Commission is pleased to issue the following guidelines for implementing "Proposition 10," The California Children and Families Act.

The State Commission hopes that the information contained in these guidelines will be of use to County Commissions in their efforts to develop comprehensive and integrated strategic plans to support young children (ages zero to five) and their families. If you have questions, please contact Dr. Patricia Skelton, Deputy Director of Research & Evaluation, or Jerri Dale, Chief Deputy Director at (916) 323-0056.

501 J Street, Suite 530
Sacramento, California 95814
(916) 323-0056

First 5 CALIFORNIA CHILDREN AND FAMILIES

COMMISSION BACKGROUND

Proposition 10, The California Children and Families First Act of 1998 (the Act), created the California Children and Families Commission, also known as First 5 California. The Commission is the leadership agency and statewide coordinator of the Act. In this leadership role, the First 5 California Commission has had the opportunity to make a significant impact on the lives of California's young children by developing a long-term public policy framework around school readiness, setting strategic goals, and integrating early childhood services into existing education, health, and social service systems.

Current research in brain development clearly indicates that the emotional, physical and intellectual environment that a child is exposed to in the early years of life has a profound impact on how the brain is organized. The experiences a child has with respect to parents and caregivers significantly influences how a child will function in school and later in life. The Act is designed to provide, on a community by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality childcare, parent education and effective intervention programs for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy and loving attachments. These attachments will lay the emotional, physical and intellectual foundation for every child to enter school ready to learn and develop the potential to become productive, well-adjusted members of society.

VISION, CORE VALUES, AND GUIDING PRINCIPLES

First 5 California Vision Statement

"Through the implementation of innovative, sustainable programs and the advancement of the understanding of the importance of early care and learning among all Californians, all young children in the State of California will reach age five physically & emotionally healthy, learning and ready to achieve their greatest potential in school."

First 5 California Core Values Statement

"Demonstrate, in our daily activities, that we are committed to serving all the youngest children of California, inclusive of those from diverse backgrounds and abilities, by providing accessible, family-friendly, culturally competent, quality childhood services and programs designed to help them achieve School Readiness."

Summary of First 5 California Guiding Principles

To guide its work, First 5 California developed the following Guiding Principles. These principles are intended to be overarching statements that guide all Commission activities and responsibilities.

I. Support families as children's primary caregivers and first teachers.

II. Ensure that families from all of California's culturally, linguistically, and geographically diverse populations, including those with disabilities and other special needs, can connect to a system of services that is easy to access, use and understand.

III. Promote policy enhancements and system changes that will support the healthy development and school readiness of all California children.

IV. Incorporate the highest quality standards for programs; utilize research to support promising and best practices.

V. Focus on results, using results-based assessments and evaluations of local and state programs and strategies.

VI. Promote collaboration and partnerships, particularly with the County Commissions, across all family support systems to enhance families' ability to access those systems from any one point for all needed services.

First 5 California School Readiness Goals and Results to Be Achieved

The State Commission has established the following five goals to achieve school readiness for each of California's children. Each of these goals is being pursued under the Guiding Principles and Principles on Equity with a commitment to ensuring that each program implemented is designed to be inclusive of all of California's culturally, linguistically, and geographically diverse populations, including those with disabilities and other special needs.

Goal 1*: Early Childhood Learning and Education*. Increase the quality of and access to early learning and education for young children aged 0-5.

Goal 2: *Early Childhood Health.* Promote the prevention, early identification of and intervention in health and developmental issues.

Goal 3: *Parent and Community Education*. Promote the importance of quality early care and education for young children by providing information and tools to parents, caregivers, schools and communities.

Goal 4: *Tobacco Cessation*. Contribute to the decrease in the use of tobacco products and other harmful substances by pregnant women, parents and caregivers of young children.

Goal 5: *Organizational Effectiveness*. Ensure programs and resources are utilized and managed in the most effective manner and in accordance with state laws and regulations.

To establish a strong and clear agenda of accountability and learning, the State Commission has adopted two documents: *Results to be Achieved* (2000) and the *Research and Evaluation Framework* (2005) that provides a structure for developing the State and County Commission strategic plans and evaluation efforts. The *Research and Evaluation Framework (Framework*) document outlines the reporting requirements for local and state evaluation and the establishment of the Center for Results. The *Results to be Achieved (Results)* document provides examples of short- and long-term results, and indicators for the following four result areas to achieve school readiness for each of California's children:

Improved Child Development: Children Learning and Ready for School

Improved Child Health: Healthy Children

Improved Family Functioning: Strong Families

Improved Systems of Care: Integrated, High-Quality, Consumer-Oriented, Culturally Appropriate, and Easily Accessible Programs and Services

PRINCIPLES ON EQUITY

Recognizing significant gaps and disparities in the provision of services for children and their families and in educational, health, and other outcomes, First 5 California adopted a resolution in 1999, demonstrating its commitment and leadership in taking proactive steps to ensure that California children and their families from diverse populations, including children with disabilities and other special needs, are an integral part of the planning and implementation of Proposition 10. In 2000, First 5 California established the Advisory Committee on Diversity to serve as its policy advisors on issues related to diversity and equity. This Advisory Committee developed the Principles on Equity to be used as a guideline to ensure that the programs and services established and supported by Proposition 10 funds are both culturally and linguistically competent and inclusive in serving children with disabilities and other special needs. The Principles on Equity address four important areas: (1) Inclusive Governance and Participation,

(2) Access to Services, (3) Legislative and Regulatory Mandates, and (4) Results-based Accountability. The Advisory Committee approved the Principles on Equity on June 29, 2001, and the Commission formally adopted the Principles on October 18, 2001, as a component of the Guidelines for the County Commissions and for First 5 California activities, decisions, and program designs. (See Appendix A.)

FIRST 5 CALIFORNIA STRATEGIC PLAN AND GOALS

The First 5 California Strategic Plan for fiscal years 2003-04 through 2005-06 is designed to guide First 5 California toward the achievement of the goal of school readiness for all of California's children. In the plan, and within the school readiness

framework, the Commission identified three strategic goals that focus on the key components of school readiness and an additional goal that targets the impact of tobacco on California's children. These four programmatic goals, listed above, provide the structure for current and future initiatives that are moving First 5 California closer to realizing its vision that "*all young children in the State of California will reach age five physically & emotionally healthy, learning and ready to achieve their greatest potential in school*."

Using these goal areas, First 5 California has strategically invested funds to help ensure that children are ready to enter school healthy, ready to learn, and able to reach their full potential. First 5 California initiatives and projects addressing each of these goals are discussed in the following sections.

In furthering the First 5 goals, the State Commission, in partnership with County Commissions, launched implementation of the Health Access for All Children (Birth to 5 years of age) Initiative and the Special Needs Project. The First 5 California Commission also has continued partnerships with the County Commissions on several initiatives, implemented in prior years, which support its school readiness goals: the School Readiness Initiative; Retention Incentives for Early Care and Education Providers; Kit for New Parents; Family, Friend, and Neighbor Child Caregiver Support Project; Early Childhood Oral Health Initiative; Migrant and Seasonal Farm Workers Project; and the statewide evaluation.

Additionally, First 5 California continues its commitment to efforts that diminish and eliminate the damaging effects of tobacco products on California's young children. Through targeted outreach strategies, parental education, prenatal education, and the funding of cessation helplines, First 5 California promotes the concept that a tobacco-free environment plays a vital role in ensuring the healthy development of California's children.

The First 5 California Commission also provides revenue support to counties, such as technical assistance, augmenting allocations, matching funds, fiscal analysis and forecasting, and research and evaluation activities that support program development and program improvement and identify best practices.

VISION STATEMENT

All California children will thrive in supportive, nurturing and loving environments, enter school healthy and ready to learn, and become productive, well-adjusted members of society.

PROPOSITION 10: HELPING MEET EARLY CHILDHOOD DEVELOPMENT NEEDS

Young children learn and grow because of the key role their parents play in their

development. Although a wide range of individuals and institutions impact the health and well-being of young children, the role of parents is paramount. Parenting is much more important during the ages birth to five than we once believed. By providing children with safe, nurturing and stimulating environments, parents and caregivers influence long-term growth and development during these important early years.

During the first three years of a child's life, the early physical architecture of a child's brain is established.

- At birth, the brain is remarkably unfinished. The parts of the brain that handle thinking and remembering as well as emotional and social behavior are very underdeveloped.

- In the early years, a child develops basic brain and physiological structures upon which later growth and learning are dependent.

- The brain operates on a "use it or lose it" principle. Emotionally and socially as well, the child develops many of the abilities upon which later social functioning is based.

- The brain matures in the world, rather than in the womb; thus young children are deeply affected by their experiences.

- Their relationships with parents and other important caregivers; the sights, sounds, smells, and feelings they encounter; and the challenges they meet, affect the way a child's brain develops.

The early years of a child's life form the foundation for later development. Attention to young children is a powerful means of preventing later difficulties such as developmental delays and disturbances. Physical, mental, social, and emotional development and learning are interrelated. Progress in one area affects progress in the others. Thus, promoting child development is not limited to the academic arena of numbers and letters. The following dimensions of child development are considered important:

- Physical development: Meeting children's basic needs for protection, nutrition and health care.
- Cognitive development and social-emotional development: Meeting children's basic human needs for affection, security, social participation and interaction with others, as well as educational needs through intellectual stimulation, exploration, imitation, trial and error, discovery and active involvement in learning and experimentation within a safe and stimulating environment.

These early childhood development needs were the basis for Proposition 10, the California Children and Families Initiative.

GUIDELINES: PURPOSE AND STRUCTURE

PURPOSE OF THE GUIDELINES

The purpose of these guidelines is to assist County Commissions in the planning and design of a comprehensive, integrated strategic plan to implement the California Children and Families Act of 1998 (the Act). They are intended to guide County Commissions in developing an outcomes-based accountability approach to the investment opportunities afforded by the Act.

These guidelines contain elements the Act requires the State Commission to address, and they list those elements that are required by the Act to be included in County Commission strategic plans. Nevertheless, the guidelines themselves are intended to *suggest* pathways for achieving the ends the Act promotes; they are not prescriptive, nor is following them mandatory.

Unlike many funding opportunities that are restricted by service categories, the Act has *as its focus* the support of local decision-making and the development of integrated strategies that are determined to be most appropriate for each county. This emphasis encourages flexibility in local planning, program design, allocation and evaluation.

The primary allocation standard for County Commissions identified in the Act is specified in Health & Welfare Code Section 3031.4 where it states clearly that revenue *shall be appropriated and expended only for the purposes expressed in the Act and shall be used only to supplement existing levels of service and not to fund existing levels of service. No moneys in the California Children and Families Trust Fund shall be used to supplant state or local General Fund money for any purpose.*

STRUCTURE OF THE GUIDELINES

The guidelines are organized as follows:

- **Strategic Results**
  This section includes a discussion of the three strategic results or long range outcomes that have been identified by the California Children and Families Commission (State Commission):

  1) Improved Family Functioning: Strong Families
  2) Improved Child Development: Children Learning and Ready for School
  3) Improved Child Health: Healthy Children

This section emphasizes the importance of comprehensive, integrated planning and service delivery in achieving overarching improvements for children zero to five and their families.

- **Strategic Planning**
  This section provides an introduction to strategic planning and identifies the elements that the Act requires of each County Commission strategic plan. County Commission planning checklists and resources follow this section.

- **Focus Areas**
  This section, which is divided into four tabs in this binder, includes an introduction to each of the Act's three focus areas:

    1) Parent Education and Support Services
    2) Child Care and Early Education
    3) Health and Wellness

Each area includes information on current issues, objectives and planning considerations. Resources for each area are provided at the close of each section.

In developing these guidelines, the State Commission attempted to respond to several imperatives:

- First, the Act itself is highly prescriptive regarding elements to be included in the guidelines. These elements are largely reflected in the "Focus Areas" section.
- Second, the Act requires County Commission plans to include specific elements (a description of goal and objectives, programs to be offered, and measurable outcomes to be achieved – see the top of page 10) and these are largely included in the "Strategic Planning" section.
- The Act also requires County Commissions to integrate programs and strategies into a "consumer-oriented and easily accessible system."
  Suggestions for achieving this result are woven throughout the guidelines, but it receives special attention in the "Focus Areas" section.
- The "Strategic Results" section was developed to provide overall coherence to and vision for the guidelines.

The State Commission recognizes that these Guidelines will evolve over time; annual revisions are required by the Act. As is the case in designing and implementing any bold new initiative, lessons will be learned over the course of time. Experience will guide and direct appropriate changes to this document.

These guidelines are intended to stimulate the development of County Commission strategic plans that set forth comprehensive integrated strategies for supporting and improving early childhood development, including encouraging cultural competence and addressing challenges for children and families with special conditions.

FISCAL CONSIDERATIONS

The State Commission recognizes that the revenue generated by the Act is clearly inadequate to address all of the possible goals and objectives that a County Commission may identify in its planning process.

The State Commission encourages County Commissions to:

1. Mobilize their communities around critical issues affecting young children and their families and identify approaches that begin to meet their highest or broadest needs;
2. Consider opportunities for leveraging or matching County Commission revenue with other private, local, state or federal programs;
3. Consider long-range financial planning based on the expectation that County Commission allocations will become a dwindling revenue source;
4. Consider research findings in selecting the most effective and primary programs and strategies;
5. Consider outcomes/evaluation from the start; and
6. Consider strategies that maximize long-term impact through up-front investments (e.g., education and training of caregivers and service providers).

The State Commission recognizes that developing effective fiscal strategies is essential to the successful implementation of the Act. It also recognizes that

County Commissions may benefit from more guidance in long-range fiscal planning and management than is provided in these guidelines. To meet this need, The Association and the State Commission contracted with the Government Finance Officers Association of the United States and Canada (GFOA) to prepare First 5 Financial Management Guide (Guide). The purpose of the Guide is to help county commissions establish and refine their financial management policies and practices. The Guide contains best practices, standard practices, and in some instances, emerging practices in governmental finance. The policies and procedures included in the Guide have been tailored where possible to the specific needs and environment of First 5 commissions.

This guidance is provided as a resource to assist commissions in the development of their financial policies and practices and is not intended to be mandatory. To the greatest extent possible, the Guide relies on practices that are required by Proposition 10 enabling legislation or other sections of the state statutes governing First 5 commissions, and those that have been established by nationally recognized sources such as the Governmental Accounting Standards Board (GASB) and the GFOA. The Guide also builds on work previously commissioned by the First 5 Association, specifically in the areas of long-term financial planning, fund balance reporting, and accounting and financial reporting.

STRATEGIC RESULTS

The State Commission has defined strategic results as the overarching direction, focus or broad outcomes for improvement. It has identified three strategic results that emanate directly from the Act:

1. **Improved Family Functioning: Strong Families**
2. **Improved Child Development: Children Learning and Ready for School**
3. **Improved Child Health: Healthy Children**

The State Commission encourages County Commissions to consider these strategic results while planning programs, services and projects that *promote, support and improve early childhood development to enhance the intellectual, social, emotional and physical development of children in California* (Health and Safety Code Section 130125 (b)).

While the Act is intended to "emphasize local decision-making, to provide for greater local flexibility in designing delivery systems, and to eliminate duplicative administrative systems" (Health and Safety Code Section 13100), the Act also requires the State Commission to "define the results to be achieved" (Health and Safety Code Section 130125 (3)(c)). The specification of strategic results is a first step in meeting this mandate and provides a basis for defining, gathering and analyzing data elements that can be used in assessing the overall impact of the Act.

1. **Improved Family Functioning: Strong Families**
   Successful and strong families are those who are able to provide for the physical, mental and emotional development of their children. Young children are entirely dependent upon caregivers for survival and nurturing. It is the interaction of the parent or primary caregiver with the child that shapes the child's view of himself or herself as an individual capable of interacting with the world and achieving desired outcomes from that interaction. Parents and caregivers provide the foundation for a child's ability to create successful relationships, solve problems and carry out responsibilities. Children who are encouraged to develop a strong self-concept from an early age are more likely to achieve a productive and fulfilling life.

2. **Improved Child Development: Children Learning and Ready for School**
   The importance of preparing children to succeed in school is critical. The role of education in a child's later ability to create a healthy, fulfilling life has been well documented. Skills that allow one to problem solve and think creatively are developed in early childhood education settings and nurtured through community and parental reinforcement. The National Association of Elementary School Principals have stated that "better childhoods" would be the single greatest contributor to improvement in school achievement.

3. **Improved Child Health: Healthy Children**
   Children who are healthy in mind, body, and spirit grow up confident in their ability to live a fulfilling, productive life. Healthy children have sufficient nutrition, health care, nurturing and guidance, and mental stimulation, and they live in families and communities that value them. The research on child development and the impact of the early years emphasizes the importance of children and their mothers beginning life with healthy nutrition and healthy environments.

Clearly, these strategic results are interrelated and strategies selected to achieve them should be interrelated. The domains they encompass – prenatal care, child health, preschool education, child care, family support, parent education and community building – ideally should form a coherent whole that can be sustained over time and will produce widely valued outcomes for young children and their families.

STRATEGIC PLANNING

INTRODUCTION

Health and Safety Code Section 130140(1)(C)(ii) of the Act requires County Commission strategic plans to include, at a minimum, the following components:

1. *A description of the goals and objectives proposed to be attained;*
2. *A description of the programs, services and projects proposed to be provided, sponsored or facilitated;*
3. *A description of how measurable outcomes of such programs, services and projects will be determined by the County Commission using appropriate reliable indicators; and*
4. *A description of how programs, services and projects relating to early childhood development within the county will be integrated into a consumer-oriented and easily accessible system.*

According to Health and Safety Code Section 130140(1)(C)(i), the county strategic plan shall be consistent with and in furtherance of:

- The purposes of the Act, and
- Any guidelines adopted by the State Commission that are in effect at the time that the plan is adopted.

There are many approaches to strategic planning, and many County Commissions may already be significantly advanced in their planning. Others may need basic guidance in getting started. The following steps build on the statutory requirements listed above, as well as some more commonly utilized strategic plan development stages. They are not intended to be prescriptive or to preclude County Commissions from adopting additional strategies, which may be used in the development of local plans. County Commissions at the beginning stages of their planning may wish to consider utilizing some of the planning funds allocated to them for strategic planning consulting.

STRATEGIC PLANNING STEPS TO CONSIDER

A. Defining a County Commission Vision and Mission

Vision and Mission statements reflect the direction and values defined by an organization. The State Commission has defined a vision as a broad, general statement of the desired future. A mission is defined as a specific statement of purpose for an organization. Mission and vision language that is consistent with the purposes of the Act will likely be aligned with section 130140(1)(C)(i). County Commissions could adopt their own vision and mission statements, or they could adopt the State Commission statement.

B. Describing the Planning Process

Strategic plans often include a description of the steps to be undertaken in adopting the plan. County Commissions might wish to:

1. Briefly describe the planning process undertaken by the County Commission to produce the strategic plan;

2. Include a description of any efforts to coordinate with existing planning bodies; and
3. Explain how the County Commission sought input throughout the process from diverse stakeholders and traditionally underrepresented groups.

Each County Commission is encouraged to define the purpose of its planning process broadly. In many planning efforts, the strategic planning *document* is often understood to be the desired end product. The State Commission anticipates that the planning process itself should strengthen community infrastructure that supports families with young children.

Further, the Act recognizes the importance of ongoing public participation and review of each County Commission's strategic direction. Health and Safety Code Section 130140(D) requires each County Commission to conduct at least one public hearing on the proposed county strategic plan before the plan is adopted; Commissioners may want to include steps for making revisions based on public input in their plans.

Short-term and Long-range Planning

An advantage of strategic planning is that it allows planners to stage program implementation and the accomplishing of outcomes. Some of the goals and objectives County Commissions will establish and the outcomes they seek are more immediate or short-term in nature and can be realized more quickly. Others will be long-range and may be spread out over a period of years. Clearly, not all of the outcomes County Commissions will adopt can be accomplished quickly. The important point to remember is that a strategic plan gives County Commissions the framework within which they will work over time to establish goals and objectives, implement programs and other efforts, and achieve outcomes.

The Act calls for an annual review and revision of County Commission strategic plans, which provides County Commissions with the opportunity to revise timelines for long-range efforts as necessary.

C. Conducting a Planning Assessment

The State Commission encourages each County Commission to conduct a comprehensive planning assessment of its county, focusing on challenges and opportunities for children prenatal to five years and their families. A planning assessment may include a socio-demographic profile of the county, with particular attention to traditionally undercounted populations such as ethnic/cultural minorities and immigrants. It may also include an analysis of the strengths and gaps in community organizations, agencies and systems that may affect planning, implementation or attainment of results. Having a basic understanding of the demographics of the entire county is essential to successful County Commission planning efforts.

These findings can help define a coherent rationale for the *goals and objectives proposed to be attained* as well as a *description of the programs, services and projects proposed to be provided, sponsored or facilitated.*

Two kinds of commonly used planning assessments include needs-based assessment and asset-based assessment. Traditionally, planning assessments have focused on identifying community needs. This approach has been driven by two key factors. First, data can often be readily collected on services currently provided by government agencies and the unmet need for those services. Second, planners, program administrators, and policy makers have historically approached planning and service delivery from the perspective of overcoming problems or intervening when crises occurred.

However, this deficit identification approach may serve to minimize focus on both prevention strategies and the assets that individuals, families and communities have to contribute. Recent research on prevention strategies and the use of existing assets in community planning and community building has caused planners, service providers and policy makers to develop an interest in prevention and asset-based community planning.

Asset-based planning begins with identifying a community's capacities, needs and assets, typically including the development of asset maps. These maps may identify public and private agencies that have a presence in the community, such as businesses, schools, parks, hospitals, libraries, colleges, police departments, and community-based and government entities. Citizen associations form another important piece of community assets. Such assets include churches, synagogues, block clubs, cultural groups, service clubs, sports groups, artist groups, parent groups and networks, and other formal and informal voluntary associations. The gifts, skills and capacities of residents within communities represent other important assets that contribute toward achieving community goals.

Asset-based planning encourages developing targeted outreach to invite and support involvement from parents and other members of the community that may not otherwise participate in a more traditional planning process. Such an approach is extremely valuable, and consistent with the intent of the Act to promote prevention strategies and support community building through civic participation in the development of the county strategic plan.

An asset-based planning effort might recognize:

1) *The impact of residents and neighborhood associations on children's health*
2) *The importance of mobilizing individual, association and institutional assets; and*
3) *The importance of upgrading or developing community systems that advocate and support child- and family-friendly policies and systems to improve the quality of life for children, families and communities.*

D. Adopting an Outcomes-Based Accountability Framework:

Choosing Goals, Objectives, Indicators and Outcomes
The Act requires each County Commission to *describe the goals and objectives proposed to be attained* in the strategic plan.

While many different definitions of commonly used strategic planning terms are available, these guidelines define a **goal** as a long-run (e.g. 5-10 years) statement of desired change, based upon the vision statement. An **objective** is defined as a precise description of desired change that is short-range and measurable, and that supports the achievement of the goal. County Commissions are encouraged to consider objectives that are discrete and tangible, if not quantifiable; such an approach is consistent with the language of the Act.

In addition to the requirement for a *description of programs, services and projects proposed to be provided, sponsored or facilitated*, the Act also requires a *description of how measurable outcomes of such programs, services and projects will be determined by the County Commission using appropriate, reliable indicators.*

Finally, the Act calls for the use of *outcome-based accountability* to guide the strategic plan. When implemented effectively, an outcome-based approach can guide County Commissions through dynamic cycles of planning, allocation, implementation and evaluation. The guidelines define **outcomes** to be taken at a point in time, as the actual measure of the extent to which programs, services or projects are achieving measurable objectives.

Outcomes-based accountability puts in place a system for continuous assessment, adjustment and evaluation. Beyond asking, "What *activities* should be carried out? What should be *done*?" outcome-based planning encourages participants to address "Ultimately, *what results, what impact, what changes in the conditions of children and families* do we expect to see from the activities performed?" and to develop strategies that hold the most promise for attaining those results.

The emphasis on evaluation and measurable outcomes directs planners to consider the relationship between short-term objectives and the availability of *appropriate, reliable indicators* of progress. These guidelines define **indicators** as specific process or performance measures that are used to determine whether programs, services or projects are achieving goals and objectives. Effective indicators are strategic, measurable, appropriate, reliable and timely. Successful outcome-based planning can aid communities in monitoring program development and system changes and stimulating interim planning adjustments.

Many definitions of terms such as goals, objectives, results, outcomes and indicators exist. These guidelines propose definitions that are consistent with the language of the Act.

E. Developing Strategies

Strategies typically specify the course of action taken to achieve stated goals and objectives. In this case, the Act also calls for County Commissions to *describe how the programs, services and projects that will be provided, sponsored or facilitated by the County Commission will be integrated into a consumer-oriented and easily accessible system.* The State Commission encourages each County Commission to explain how the selected strategies will be coordinated to improve family functioning, child development and child health, and how consumers will access these services. The State Commission also encourages County Commissions to describe strategies used to reach out to traditionally underrepresented groups, including ethnic/cultural minorities, immigrants and limited English-speaking communities.

F. Allocating Resources: Fiscal Considerations

The next step in strategic planning generally involves identifying and allocating funds needed to implement the strategies that have been selected. The intent of the Act is to provide resources to County Commissions *for the support and improvement of early childhood development* (Health and Safety Code Section 130140(1)(C).

The Act does NOT specify the criteria for County Commissions in making allocation decisions. However, the Act states clearly that revenue *shall be appropriated and expended only for the purposes expressed in the Act and shall be used only to supplement existing levels of service and not to fund existing levels of service. No moneys in the California Children and Families Trust Fund shall be used to supplant state or local General Fund money for any purpose* (Revenue and Tax Code Section 3031.4).

County Commissions are encouraged to develop a fiscal component in their strategic plans. The funds allocated to each County Commission will vary greatly. Some will receive large amounts; funding for others will be extremely modest. In either case, the funds provided directly by the Act will never be sufficient to meet all the needs identified by local Commissions or the goals of the Act itself. Consequently, County Commissions are urged to consider the following issues in their deliberations:

2. Consider using funds to mobilize the community around key issues in early childhood development and enlist the support of local businesses, educational institutions, community-based organizations and local government.
3. Consider opportunities for leveraging or matching County Commission revenue with other private, local, state or federal programs.
4. Consider both research findings that show that investment in low-income areas has a heightened impact, as well as comprehensive strategies that can improve conditions for *all* children, families and communities.

5. Consider long-range financial planning, based on the expectation that County Commission allocations will become a dwindling revenue source. Examine the institutional relationships, additional funding sources and innovative fiscal strategies that comprise the County Commission's best options for sustaining its mission.

6. Consider opportunities to apply for gifts, grants, donations or contributions of money, property, facilities or services, especially in support of community building.

G. Planning for Evaluation

Evaluation is the consistent, ongoing collection and analysis of information for use in decision-making in implementing programs and assessing their effectiveness. The State Commission strongly encourages each County Commission to consider evaluation as a critical component of its strategic plan, as well as of individual project development and ongoing project administration. Evaluation is an essential tool in reviewing progress toward achieving the strategic results.

Useful evaluation techniques can include individual interviews, written surveys, focus groups, observation and analysis of statistical information. The purpose of evaluation is not just to prove whether desired outcomes have been reached, but to improve the process of strategic planning. For evaluation to be the most beneficial, it should be incorporated in every phase of the strategic plan, from project development, through start-up, to implementation and expansion or replication phases. Evaluation should be conducted in such a way that it provides direct feedback to the County Commission and to the community as a whole.

H. Being Inclusive

The Act requires County Commissions to develop an integrated and "consumer-oriented and easily accessible system" of programs, services and projects. Giving voice to a range of perspectives during the planning stage ensures that critical viewpoints, particularly those of parents, are not left out of program design. Involving parents and community members can engender support from a broad array of constituents. The State Commission urges County Commissions to be as inclusive as possible in designing and adopting their strategic plans.

PLANNING CHALLENGES TO KEEP IN MIND

In developing county strategic plans, each County Commission is required to *describe how programs, services and projects relating to early childhood development will be integrated into a consumer-oriented and easily accessible system*. In developing their plans, County Commissions are encouraged to consider four cross-cutting considerations that affect the development of consumer-oriented and easily accessible systems:

1. Emphasizing an outcomes-based accountability framework;
2. Maximizing opportunities to develop integrated service strategies and delivery systems;
3. Encouraging cultural competence; and
4. Addressing children and families with special conditions.

1. Outcomes-Based Accountability

As noted in previous pages, the Act calls for the use of an outcomes-based accountability approach to guide strategic planning. While many definitions of terms and approaches are possible (sometimes it is called “results-based accountability”), all share a common focus on achieving outcomes as opposed to measuring services delivered. Whatever scheme County Commissions choose, the key to most successful outcomes-based accountability approaches lies in selecting and describing the desired outcomes or conditions of wellbeing that are sought (preferably stated in positive terms), designing strategies to achieve them, and determining measures (or indicators) that gauge the extent to which the desired conditions are achieved. First 5 California has developed, as a resource, the Child, Family, and Community Indicators Book (August 2002).

2. Integrated Service Strategies

The Act encourages the development of comprehensive strategic plans that promote integration, linkage and coordination among programs, service providers, revenue resources, professionals, community organizations and residents in an overall effort to strengthen communities and support children and families.

In promoting integration, County Commissions may anticipate challenges with integrated service models and develop strategies to address them directly. Challenges that are frequently cited include:

- Maintaining focus on the outcomes to be achieved
- Identifying sustainable funding
- Dealing with staff turnover
- Achieving comprehensive integration
- Ensuring confidentiality of participant information
- Dealing with federal or state statutory requirements that prohibit the blending of funds or services
- Addressing the lack of training/experience with service integration
- Overcoming geographic distance, language or cultural differences

The flexible nature of funds from the Act offer County Commissions the opportunity to overcome many of these barriers.

Many successful models of integrated services exist in California and throughout the nation. Key strategies that have contributed to successful integration of services include:

- Public/private partnerships
- Strong leadership
- Extensive, inclusive planning
- Strong communication practices among member agencies
- Clear focus on outcomes and results
- Shared data resources or the development of original data
- Broad inclusion of participants in decision-making
- Interdisciplinary training and technical assistance to staff
- Well-defined governance structures

While County Commissions may consider the merits of establishing new partnerships and linkages, they are not required to develop new service collaboratives in response to the Act. Many counties already have existing collaboratives, networks or partnerships that could form the basis for linking and integrating the programs and services identified in the Act. County Commissions may wish to assess how existing collaboratives in the community already serve children and families; this review may include fiscal management, community representation, historical reliability in meeting outcomes and capacity.

> *Shifting the emphasis from crisis intervention to anticipatory guidance and support of families with young children at the first moments when parents or other caregivers need assistance promotes family and child stability. In families where parents and caregivers have the economic and personal resources to nurture children, children are more likely to grow up healthy, ready for school, prepared to contribute to society and to lead productive and fulfilling lives.*

The following chart serves as an example for County Commissions in planning strategies to provide comprehensive and integrated services. It provides information about the main elements of comprehensive integrated services and systems, and suggests indicators to use in measuring progress. The table suggests that County Commissions interested in comprehensive integrated services may consider changes in the way they design and deliver services, collect, analyze and disseminate data, develop policy and finance programs, and other activities.

For example, data that are available, accessible, shared, integrated and confidential are more supportive of comprehensive integrated systems than data that are hard to find (or don't exist), are only shared with a select few, and are only available in a narrow, categorical program database that cannot be connected to other programs or service providers.

The middle column of the chart offers descriptors of system change elements to consider. The last column describes how to recognize if you are making progress toward a system that is supportive of comprehensive integrated services.

For example, comprehensive, integrated policy tends to be developedwhen informed by data and information from multiple sources, especially from research and residents. If your County Commissionregularly conducts or reviews data from focus groups in key policy areas such as readiness for schools or keeping kids safe at home, and you use that information to inform your policy decisions, you are making progress towards your goal. If you base funding decisions for programs on a review of program outcomes, not just on how much they received last year, you are also moving toward your goal.

System Dimension	Descriptors	Indicators
Prevention & Promotion	Family-Centered	• Public information campaigns • Informed community
Service Delivery	Comprehensive	• Services responsive to needs • Continuum from prevention to treatment • Culturally competent providers
	Integrated	• Provider agreements/Memorandum of Understanding for shared services • Single point of entry • Co-located services • Multi-disciplinary teams with single family case manager • Improved referrals and follow-up
	Accessible	• Co-located services • School-linked/community-based services • Culturally competent providers • Informed consumers • Satisfied consumers • Consumer/resident input
Data	Available, accessible and shared	• Widely accepted list of results and indicators for children that crosses agency/discipline lines • Regular tracking and reporting of results and indicators • Regular agency performance reports that relate to results and indicators • Databases accessible from multiple locations to planners, policymakers, providers, residents
	Integrated	• Standardized data entry and reporting • Translation standards across categorical data systems • Family case management data systems

	Confidential	• Single customer information release form across agencies/systems • Standard protections in reporting disaggregated data
Policy	Informed by data/information, residents	• Regular resident input beyond public hearings, e.g., surveys, etc. • Funding decisions based on results/ indicator and agency performance data • Policies/program implementation revised as new information surfaces
	Collaborative	• Policy decisions focused on improving performance in results and indicators • Joint public hearings across health, education and social services • Joint agency presentations
Finance	Results-based	• Widely accepted list of results and indicators for children that crosses agency/discipline lines • Regular tracking and reporting of results and indicators • Clear targets for indicator improvement • Regular agency performance reports that relate to results and indicators • Funding decisions based on results/indicators and agency performance data
Finance (cont.)	Flexible funding	• Organizational agreements to share resources across agency lines/categorical programs • Program funding streams with wide local spending latitude tied to program results

3. Universal Access to Culturally Competent Systems and Services

The issues related to access and appropriateness of service delivery are increasingly important as California's population continues to diversify.

Lack of awareness about cultural differences can make it difficult to achieve optimal outcomes for children and families. Nationality, ethnicity, and cultural as well as family background and individual experiences all affect beliefs, practices and behavior on the part of the individual, the community and the service provider; they also influence the expectations that each have for the other.

The California Department of Health Services has developed a definition of cultural competence which may guide County Commissions as well as service providers and other care providers for children and families. While intended for providers in the field of health, the definition is broadly applicable to all who work and interact with families and children.

> *"Culture is comprised of a group's learned patterns of behavior, values, norms, and practices. Organizational cultural competency is the ability of … organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds.*
>
> *Cultural competency requires the recognition and integration by … professionals of an individual's behaviors, values, norms, practices, attitudes, and … beliefs. Development and incorporation of these interpersonal and intra-cultural skills should effect a positive change in the manner in which … care is delivered to culturally diverse [populations]. Being culturally competent means improved communication between providers and [individuals] who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and …*

Because cultural competency is neither finite nor static, it should not be viewed as a set of behaviors that can be acquired definitively. Rather, it is a continually evolving process that requires constant vigilance to improve cultural understanding and to assure the quality of service delivery.

The development of outcome measures that capture the impact of cultural competency is still in a nascent state. However, given the demographics of California's prenatal to five-year-old population, it is critical to develop programs that consistently and effectively address the needs of children and their families from diverse communities. Data should, when possible, be disaggregated by race, ethnicity, primary language and other demographic variables so that differences in outcomes among groups can be analyzed and targeted strategies to address these differences can be developed and executed.

On June 29, 1999, the State Commission issued the following statement regarding eligibility for services funded with revenues from the California Children and Families Trust Fund.

> *The State Commission has received a number of inquiries regarding the eligibility for services and programs funded under the California Children and Families Act of 1998 ("the Act"). Consistent with the letter and intent of the Act, eligible children are children prenatal to five years of age, residing in California. Services and programs funded, in whole or in part, by revenue generated as a result of this Act, shall not be denied due to an eligible child's immigration status.*

(Although the integration of services is highly recommended, providers administering federal, state, and California Children and Families Act programs should be cautious not to include possible immigration requirements for federal and state programs with the California Children and Families Act, for which there are no restrictions based on immigration status.)

4. Addressing Children with Special Needs and Their Families

Juggling the demands of young children with the responsibilities of work and home are challenging for all families. For families whose children have disabilities or other special needs, the added responsibility of accessing adequate supports and negotiating the various service systems is overwhelming. Parent education and family support programs address a wide range of challenges and can include early intervention, special education, mental health, treatment and support for victims of domestic violence, child abuse and neglect, and substance abuse. Attention to comprehensive integrated services and programs is critical when addressing the complexities of children, families and communities with special needs.

Special health needs may also arise when a child, parent or caregiver has a severe and/or chronic mental or physical impairment. This kind of impairment, often referred to as a developmental disability or chronic disease, is attributable to one of the following conditions: mental retardation (a symptom with many possible genetic and acquired causes), cerebral palsy, autism, epilepsy, visual or hearing problems, or another chronic disabling condition requiring ongoing treatment.

Coordinated early intervention services to promote child development and enhance family capacity are critical during a child's early years. Research shows that participation in family-centered early intervention services during the first years of life can have significant positive effects on the cognitive development, social adjustment and overall development of at-risk children and their families.

Children with special needs and their families often experience challenges in receiving the level and type of care appropriate to meet their needs. There are a number of public and private programs that provide services to this population, but their use is restricted to meeting specific eligibility criteria that can limit access and continuity in care. Some resources are the Children's System of Care (through county mental health departments), the Department of Developmental Services, Regional Centers, local education agencies (special education, adult education services), community-based organizations, support and volunteer groups.

Primary and specialized services that are family-centered and coordinated with other services to address parent education and referral, health care, child care, respite care, counseling, support and employment assistance are especially critical for this population. Challenges with coordination, cultural competence, transportation and communication are additional barriers affecting access and utilization.

PLANNING CHECKLISTS AND REFERENCES

The following pages contain resources in the form of checklists, charts, planning considerations, approaches from related programs and references that County Commissions may find useful. The resources are not prescriptive, nor are they comprehensive. The State Commission intends to provide additional guidance, support and technical assistance to County Commissions and their communities through other venues and over time.

COUNTY COMMISSION STATUS CHECKLIST

- ❑ Has your county adopted an **ordinance** to establish the Children and Families County Commission? Section 130140(1)(A).

- ❑ Has your county established a County Commission Families and Children Trust Fund? Section 130105(2)(A).

- ❑ Has your County Commission established one or more **advisory committees** to provide technical and professional expertise and support for any purposes that will be beneficial in accomplishing the purposes of the Act? Section 130145.

- ❑ Has your County Commission developed a **strategic plan** that includes the following required components? Section 130140(1)(C)(ii).

    a) A description of the goals and objectives proposed to be attained;
    b) A description of the programs, services and projects proposed to be provided, sponsored or facilitated;
    c) A description of how measurable outcomes of such programs, services and projects will be determined by the County Commission using appropriate reliable indicators; and
    d) A description of how programs, services and projects relating to early childhood development within the county will be integrated into a consumer oriented and easily accessible system.

- ❑ Has your County Commission conducted at least one **public hearing** on its proposed county **strategic plan** before the plan is adopted? Section 130140(1)(D).

- ❑ Is your County Commission's proposed strategic plan consistent with and in furtherance of the purposes of the Act and any guidelines adopted by the State Commission at the time the plan is adopted? Section 130140(1)(C)(i).

- ❑ Does your County Commission's proposed strategic plan recognize that revenue allocations from the State Commission shall be used only to **supplement** existing

levels of service and not to fund existing levels of service? Does your County Commission's proposed strategic plan recognize that no moneys in the California Children and Families Trust Fund shall be used to supplant state or local General Fund money? Section 3031.4.

- ❑ Has your County Commission adopted an **adequate and complete** county strategic plan for the support and improvement of early childhood education within the county? Section 130140(1)(C).

- ❑ Has your County Commission **submitted** its **adopted** county **strategic plan**, and any subsequent revisions to the State Commission? Section 130140(1)(F).

SERVICE INTEGRATION QUESTIONS

Following are questions that County Commissions may find useful in planning for service integration.

1. Will our efforts expand the available services and supports to young children and their families?
2. Do our efforts fill a gap in the continuum of service from prevention to treatment?
3. Can families enter the entire system from any one of the collaborative partner sites?
4. Is there a strong and active system of mutual referral and follow-up on referrals?
5. Are multiple services available at single sites?
6. Do teams of workers from across several disciplines work in unison with the family?
7. Is there one person in the system who acts as the point of contact for the family and for the other service providers?
8. Are services available in neighborhoods or in areas and facilities easily accessible to families (schools, churches, community centers, traveling vans, etc.)?
9. Are parents and families part of the decision-making and feedback loops?
10. Are programs and providers able to provide services and supports to people of multiple cultures in a competent manner?
11. Is there an agreed upon set of results and indicators in place across agencies and programs?
12. Are there regular performance reports by providers that relate to the agreed upon results?
13. Are there standardized data fields and reports?
14. Are there organizational agreements in place that provide for shared resources and funding across programs and agencies?
15. Is there a single release of information form available that balances a family's need for confidentiality with service providers' need for data and information sharing?
16. Is there a plan for regular public polling, public hearings and public input to keep both programs and systems informed?

17. Is there an effort to create responsible media coverage of efforts and results?
18. Are policy decisions focused on improving performance in results and indicators?
19. Are results tracked on a regular basis?
20. Are there clear targets for improvement?
21. Are funding streams tied to performance and results?

SERVICE INTEGRATION STRATEGIES

Following is a list of planning considerations and strategies that County Commissions may find useful in examining opportunities for integrated services and systems to improve early childhood education.

- Identify goals for different segments of the population, such as specific service goals, family goals, policy goals and community goals. Encourage the development of new data sources and new measures where appropriate.
- Develop strategies to achieve goals and objectives that flow from the needs and assets assessment and reflect available resources.
- Develop strategies that consider innovative projects, available research and best practices.
- Link goals and outcomes to an evaluation process, and describe the mechanism that will be used to determine whether projects are working. Use continuous evaluation and monitoring for program improvement.

Service Integration Strategies for Consideration

- ✓ Improve existing service sites, such as child care centers, so that they offer more comprehensive services.
- ✓ Improve coordination between existing public and private services, including Women Infant and Children Programs, Temporary Assistance to Needy Families, Head Start, Healthy Start, immunization and oral health programs, health clinics.
- ✓ Support efforts to increase the utilization of existing programs – e.g. Medi-Cal, Healthy Families, Assistance to Indigent Mothers Program, child care food programs.
- ✓ Support efforts to integrate new topics into practitioners' and providers' existing education, training and service approaches – e.g. topics such as pregnancy, parenting, child development, nutrition, safety, mental and oral health.
- ✓ Develop child care centers that also serve as Family Resource Centers.
- ✓ Create mobile education and service teams.
- ✓ Develop centralized resources such as registries, pools and waiting lists.
- ✓ Support efforts to increase interdisciplinary training for service providers – on topics such as infant and child development, best practices for working with young children, business/facilities planning and management, available resources in the community, cultural competence, vaccines, identifying at-risk mothers, identifying oral and mental health conditions.
- ✓ Increase the number of culturally competent professionals who serve children and families.
- ✓ Develop materials and other resources in different languages that facilitate interdisciplinary education for parents and providers—e.g. guides and hotlines.
- ✓ Identify and develop public and institutional policies to improve services for children and their families.

PLANNING PARTICIPATION

The following is a list of planning considerations that County Commissions may find useful in encouraging diverse participation in the development of strategic plans.

- Minimize barriers such as transportation, language preference, child care, location and timing of meetings to increase the potential for community involvement, especially from parents and other caregivers.

- Target efforts to fully integrate parents and families, including those with special needs, into the planning process.

- Encourage community participation in the planning process, including ethnic/cultural, income and geographic diversity.

- Encourage participation from individuals who may be recipients or participants in the proposed programs, services and projects, especially those individuals living and working in under-served geographic regions or neighborhoods.

- Encourage involvement of experts in the areas of child care, child development, brain research, child health, maternal health, family support, parenting education.

- Encourage participation from staff of model programs that already coordinate, link and integrate their activities and resources in ways that facilitate easy access to a comprehensive array of services for children and families in their community.

- Encourage the participation of staff whose roles and practices may change in order to make services more available and accessible to families. *This may include representatives of agencies that offer a variety of services on their sites or the staff who may be responsible for forging new linkages, making referrals, or joining mobile and interdisciplinary service teams; or providers who may incorporate new topics or services into their traditional practices/presentations.*

- Encourage participation from representatives of private sector institutions including foundations, businesses and corporations.

- Support continuous quality improvement processes that increase communication between consumers/communities/families and the systems that serve them.

PLANNING TERMINOLOGY

The State Commission will use the following operational definitions for these strategic planning terms.

Vision

Definition: A broad, general statement of the desired future.

Example : All children will thrive in supportive, loving and nurturing environments, enter school ready to learn and become productive, well adjusted members of society.

Mission

Definition: A specific statement of purpose for an organization.

Example: The AB Children and Families County Commission is committed to ensuring timely, culturally competent, client centered and comprehensive and integrated services to maximize the intellectual, social and physical development for all children.

Principles
Definition: The values and beliefs that provide guidance and inspiration to the organization.

Example: Develop creative methods to invite cultural/ethnic, income and geographic diversity in the planning process.

Strategic Results
Definition: The overarching direction, focus or broad outcomes for improvement. The California Children and Families Commission has chosen the following broad outcomes:

1) Improved Family Functioning: Strong Families
2) Improved Child Development: Children Learning and Ready for School
3) Improved Child Health: Healthy Children

Goal
Definition: A long-run (e.g. 5-10 years) statement of desired change, based upon the vision statement.

Example: Improve developmental readiness scores.

Objective
Definition: A precise description of desired change that is short-range and measurable, and that supports the achievement of a specific goal.

Example: Decrease by 20 percent over two years the proportion of preschoolers with indicators of anemia as measured through the Pediatric Nutrition Surveillance System.

Indicator
Definition: Specific process or performance measures that are used to determine whether programs, services, or projects are achieving goals and objectives.

Example: The proportion of licensed caregivers who have received adequate training in the practical application of early childhood development techniques.

Strategy
Definition: The course of action taken to achieve a stated objective.

Example: Increase the use of Community Health Outreach Workers (CHOWs) in communities where English is not the primary language, to improve community awareness regarding the importance of well baby visits, nutrition and immunizations.

Outcome
Definition: Taken at a point in time, the actual measure of the extent to which programs, services, or projects are achieving measurable objectives.

Example: After two years, the proportion of pregnant teens who smoke was reduced by 14 percent. CSSP, FPSI and The Lewis Carroll Center for Language Disorders

Results Accountability **Some References in Prop. 10**		
Population:	**"Children ... from the prenatal state to five years of age"**	
Strategic Results:	**"Children ... enter school in good health, ready and able to learn, emotionally well developed"**	
Indicators:	**Percent of low birth weight babies** **Rate of preterm deliveries** **Rate of infant death (incl. SIDS)** **Rate of severe physical developmental complications** **Rate of lower respiratory tract infections in infants and children under 18 months of age** **Rate of hospitalizations**	
Partners:	**Child Care Providers**	**Governor**
	Child Care Workers	**Legislature**
	Media	**Board of Supervisors**
	Tobacco/SA Treatment	**Corporations**
	Educators	**Foundations**
	Public Health	**Medical, Pediatric and Obstetric Associations**
	Behavioral Health	**Secretary HSSA**
	Social Services	**Secretary CDE**
	Recipients of Service	**State Commission**
	Family support centers	
What works:	**- <u>Comprehensive, collaborative, integrated, consumer oriented, easily accessible</u> system of information and services**	
	- <u>Child care</u>: high quality, accessible, affordable	
	- <u>Parent education</u>: nutrition, care and nurturing, child development, child abuse prevention	
	- <u>Child health care services</u>: prevention, diagnosis, treatment, pre and post natal maternal health, nutrition, tobacco and substance abuse treatment...	
	- <u>Parental Support:</u> family support centers, domestic violence prevention and treatment, family services and	

	counseling
	- Mass media communications: for the general public on nurturing, **parenting, selection of child care, prevention of tobacco and drug use** **by pregnant women...**

FPSI

Children Ready for School

Experience / Indicators

How we **experience** this condition:

Enthusiastic about school
Dressed appropriately for the season
Familiar with literacy concepts
Do not experience violence
Interacting appropriately with peers
Social interaction skills on playground
Hygienic in bedroom and bathroom
Well nourished
Coordinated fine and gross motor skills
Parental enthusiasm
Positive self image
Able to communicate

How we could **measure** this condition:

Rate of complete immunizations at ages 2, 5
Percent who pass K and go on to 1st grade after 1 year
Peabody Verbal - average score or better after 1 year
Rates of child abuse/neglect ages 0-5
Rate of behavior referral among kindergarten students
School attendance rate for kindergarten
Rate of hospitalization
Reading at grade level 1st, 2nd and 3rd grades
Percent in foster care ages 0 – 5

REFERENCES and RESOURCES

Many of the listings that follow were culled from the *Results-Based Accountability Project at the Harvard Family Research Project.* Their full list is located on the Internet site at: http://gseweb.harvard.edu/~hfrp/releases/rba/

General Information on Strategic Planning

Bay Area Partnership: Building healthy and self-sufficient communities for economic prosperity. Promising Bay Area community building initiatives: Profiles and analysis. **Northern California Council for the Community, 1996.**

Building communities from the inside-out: A path toward finding and mobilizing a community's assets. **Kretzmann, John P. and McKnight, John L., ACTA Publications, 1993.**

Council of Governors' Policy Advisors (CGPA): Produces reports on developing results-based accountability systems that specifically discuss development of strategic plans. To obtain information, contact: CGPA, Hall of the States, 400 N. Capitol Street, Suite 390, Washington, DC 20001-1511. Tel: (202) 624-5386; fax: (202) 624-7846.

Family Investment Trust. (1995). ***Missouri's direction for change: Achieving better results for children and families.*** **St. Louis, MO.**

Friedman, Mark. (1996). ***A strategy map for results-based budgeting: Moving from theory to practice.*** **Washington, DC: The Finance Project.**

Indiana Family and Social Services Administration: Developed a strategic plan to guide the state agency. To obtain information, contact: Indiana Family and Social Services Administration, 402 W. Washington Street, P.O. Box 7083, Indianapolis, IN 46207-7083.

Laying the groundwork for change: Los Angeles County's first action plan for its children, youth and families. **Developed by the Los Angeles County Children's Planning Council, February 1998.**

Minnesota Planning: Developed statewide strategic plan and ***Minnesota milestones: A report card for the future*****.** To obtain information, contact: Minnesota Planning, 658 Cedar, St. Paul, MN 55155. Tel: (612) 296-3985. http://www.mnplan.state.mn.us/

Missouri Family Investment Trust: Developed a strategic plan to guide better results for children and families. To obtain information, contact: The Family Investment Trust, 3915 W. Pine Blvd., St. Louis, MO 63108. Tel: (314) 531-5505.

Oregon Progress Board: Responsible for translation of Oregon strategic plan into goals, indicators and benchmarks. To obtain information, contact: Oregon Progress Board, 775 Summer Street, N.E., Salem, OR 97310. Tel: (503) 986-0039.

General Information on Outcome- and Results-Based Accountability

Campbell, M. D. (ND). *Outcome and performance measurement systems: An overview.* Washington, DC: Alliance for Redesigning Government.
The article includes a short discussion of outcomes for states and communities, performance-based budgeting, and investment decision-making. This short overview is useful for those who are not familiar with the development and potential uses of outcome-based systems.

Center for Assessment and Policy Development: Produced a paper on challenges and potential benefits of developing an outcomes orientation. To obtain information, contact: 111 Presidential Boulevard, Suite 234, Bala Cynwyd, PA 19004. Tel: (215) 664-4540; fax: (215) 664-6099.

Chynoweth, J. K. & Dyer, B. (1991). *Strengthening families: A guide for state policymaking.* Washington, DC: Council of Governor's Policy Advisors.
This guide, based on the experience of ten states, offers a practical approach to policy design that reflects the importance of the family in the development of children and society. It moves away from traditional, categorical, symptomatic design toward a focus on realistic and logical assessments of and outcomes for families. It notes that performance and policy accountability systems are vital to guiding this type of policy, and are helpful when used as management tools.

Council of Chief State School Officers: Produces issue briefs and reports on collaborative and coordinated child and family services, as well as state resultsbased accountability efforts. To obtain information, contact: Bill Shepardson, 1 Massachusetts Avenue, N.W., Washington, DC 20001-1431. Tel: (202) 408-5505; fax: (202) 408-8072.

The Finance Project: Produces publications on finance issues related to resultsbased accountability for child and family services. To obtain information, contact: 1341 G St, N.W., Washington, DC 20005. Tel: (202) 628-4200; fax: (202) 628-4205.

Gardner, S. L. (1991). Community accountability for children: Cross-cutting outcome measures at the community level. Cambridge, MA: John F. Kennedy School of Government.
This paper was developed from the discussions of the Executive Session on Making the System Work for Poor Children convened by the Malcolm Weiner Center for Social Policy. The members of the Executive Session represented diverse sectors serving poor children: social services, health care, income maintenance, education and others. The goals were to diagnose problems in the current system of services for poor children, and to develop recommendations for making the system more responsive to

the needs of children and their families. This working paper discusses one of these recommendations, outcomes-based accountability at the community level. The advantages and problems of a move to this kind of system are discussed.

Harvard Family Research Project. (1996). Evaluation Exchange Newsletter: Emerging Strategies in Evaluating Child and Family Services. Cambridge, MA.
This issue (Vol. II, No. 1) begins with an overview of accountability systems, discussing both the opportunities and challenges they present, as well as brief descriptions of two states, Minnesota and Oregon, that have developed resultsbased accountability systems. Results-based accountability systems obviously need indicators to measure whether or not results have been achieved. Kristen Moore and Brett Brown of Child Trends bring us up-to-date on the field of child indicators in the 1990s. Nancy Dunton, with the New York State Department of Social Services, discusses some of the challenges to data capacity for outcomebased accountability.

Improved Outcomes for Children Project, Center for the Study of Social Policy: Developed reports on outcome based accountability. *Finding the data: A start-up list of outcome measures with annotations.* To obtain information, contact: 1250 Eye Street, N.W., Suite 503, Washington DC 20005.
Tel: (202) 371-1565; fax: (202) 371-1472.
This companion document to "The Case for Shifting to Results-Based Accountability" was developed to help communities determine the outcomes on which data are already being collected, and find the data in their community. The aim was to do as much of the "legwork" as possible in order to make it easier for states and communities to determine how their families were doing. For each of the outcomes in the core list contained in "The Case for Shifting to Results-Based Accountability," this document provides information about: how that outcome can be measured; what cautions should be heeded in collecting data; and where data can be found on a national, state, and local level. Appendices list many organizations, by state, that collect data on topics such as child welfare, juvenile justice, educational scores, child health, and other areas. This document is an important resource for individuals involved in developing systems of results-based accountability.

Kagan, S. L. (1995). *By the bucket: Achieving results for young children* (Issue Brief prepared for The Governors' Campaign for Children, The National Governors' Association). Washington Association.
This issue brief provides a conceptual framework for states beginning the process of focusing on enhanced accountability for children and their families. The issue brief describes four categories, or "buckets," of data that can be used to measure results for children, families, services, and systems: (1) what children know and can do; (2) child and family conditions; (3) service provision and access; and (4) systems capacity. It provides an interesting framework for thinking about the processes and mechanisms for developing outcomes for children and their families.

Oregon Commission on Children and Families: Produces numerous relevant publications, particularly the Outcome measurement notebook: 1995-1997 (Portland, OR: Oregon Commission on Children and Families, 1995).
This notebook, designed to help local Commissions on Children and Families in

Oregon develop outcome measures, includes sections on the use of information in comprehensive planning, research on model programs and sample measurement methods for frequently measured outcomes. To obtain information, contact: Oregon Commission on Children and Families, 800 N.E. Oregon Street, Suite 550, #13, Portland, OR 97232.

Schorr, L., Farrow, F., Hornbeck, D., & Watson, S. (1995). ***The case for shifting to results-based accountability with a start-up list of outcome measures.*** **Washington, DC: Improved Outcomes for Children Project and the Center for the Study of Social Policy.**
This paper sets out some of the issues in the shift to results-based accountability, and identifies a list of outcome measures with annotations on their use. The authors see results-based accountability as an essential part of a larger strategy to improve outcomes for children. This paper sets the stage for later discussions of how these outcomes can be translated into a program agenda; how that program agenda can then lead to a budget and financial plan; and how, over time, resultsbased accountability can be combined with both rewards and penalties based on performance.

Stephens, S. A., Leiderman, S. A., Wolf, W. C., & McCarthy, P. T. (October 1994). ***Building capacity for system reform.*** **Bala Cynwyd, PA: Center for Assessment and Policy Development.**
Discussing the capacities that need to be built to support system reform, this paper notes the importance of an outcome orientation in changing systems of service for children and their families. This paper notes that even in the absence of ideal conditions for measuring improvements in outcomes, there is value in outcomes oriented planning and implementation. While the authors acknowledge the technical and resource challenges in developing an outcomes orientation, they delineate the potential benefits of such an orientation as a strategic planning tool. The paper provides a good summary of the challenges and potential benefits of developing an outcomes orientation.

Young, N., Gardner, S., Coley, S., Schorr, L., & Bruner, C. (1994). ***Making a difference: Moving to outcome-based accountability for comprehensive service reforms.*** **(Resource Brief #7). Falls Church, VA: National Center for Service Integration.**
This resource brief contains three chapters that address various aspects of accountability systems for child and family services programs. One chapter provides a conceptual framework for understanding and examining outcomes within the context of goals, strategies, and resources. Another chapter describes the rationale for outcomes-based accountability systems and provides a preliminary list of child outcome measures that can be used to assess progress. The final chapter describes the challenges in measuring the impact of service strategies and suggests a new approach to evaluating comprehensive, community-based service reform efforts. There is a lot of useful information packed into a few pages.

American Humane Association: Produces publications and sponsors an annual roundtable on outcome measures for child welfare services. To obtain information, contact: 63 Inverness Drive E., Englewood, CO 80112-5117. Tel: (303) 792-9900; fax: (303) 792-5333.

Brown, B. V. (1994). *Indicators of children's well-being: A review of current indicators based on data from the Federal Statistical System*. Washington, DC: Child Trends.
This paper familiarizes the reader with the numerous indicators of children's wellbeing currently in use which are based on federal data. The indicators reviewed were taken from existing government and private publications that feature descriptive measures of children's well-being. As such, they do not exhaust all of the important measures of child well-being that are available from the vast federal statistical system, nor do they tap the range of measures that could be created. In the text itself, the following items are discussed for five topic areas (health; education; economic security; population, family and neighborhood; and social development and problem behaviors): the major data sources from which most of the indicators are constructed; a brief description of the indicators themselves; and a brief discussion of any obvious limitations of the existing set of indicators in each area.

Child Trends, Inc.: Produces research and publications on indicators related to children and families. To obtain information, contact: 4301 Connecticut Avenue, N.W., Suite 100, Washington, DC 20008. Tel: (202) 362-5580; fax: (202) 362-5533.

Child Trends, Inc., SRI International (August, 2002). *Child, Family, and Community Indicators.* *www.prop10evaluation.com*

Council of Chief State School Officers. (September, 1993). *Identifying crosscutting outcomes for use as a focal point for change.* (Issue Brief). Washington, DC.
This issue brief discusses the process of identifying a broadly defined set of desired outcomes for children and youth. It looks at the experiences of a few states making progress in this area in order to shed some light on the implications for state education agency policy and practice. The issue brief presents some principles to be considered in ensuring that outcome-based education efforts are compatible with and supportive of more comprehensive attempts to achieve collective, cross-sector accountability for the well-being and success of children and families. It provides descriptions of indicators in this area, including their significance, data requirements, and data sources.

Institute for Research on Poverty, University of Wisconsin-Madison:
Sponsors annual conference on indicators of children's well-being; conference papers are available from the Institute. To obtain information, contact: 1180 Observatory Drive, 3412 Social Science, Madison, WI 53706. Tel: (608) 262-6358; fax: (608) 265-3119.
This three-volume set includes the proceedings, background and conference papers of the November 1994 conference on "Indicators of Children's Well-being" sponsored by the Institute. Volume I includes the background papers and rapporteurs' comments;

Volume II includes the papers on indicators for child health, education, and economic security; Volume III includes the papers on indicators for social development and problem behaviors as well as cross-cutting issues and papers on population, family and neighborhood. Short summaries of the papers and the conference are included in the Institute's newsletter, *Focus* (Vol. 16, No. 3, Spring 1995).

Moore, K. A. (1994). *Criteria for indicators of child well-being*. Paper prepared for Indicators for Children's Well-being Conference, November 17, 1994, Bethesda, MD.
After highlighting a lack of clear, valid, up-to-date indicators of child well-being and the lack of consensus on what it is desirable to track, this paper goes on to present criteria for designing a system of indicators about children. Thirteen criteria are discussed in detail: comprehensive coverage; children of all ages; clear and comprehensible; positive outcomes; depth, breadth, and duration; common interpretation; consistency over time; forward-looking; rigorous methods; geographically detailed; cost efficient; reflective of social goals; and adjusted for demographic trends. This paper provides a detailed discussion of important issues in designing an indicators system to track child well-being.

Budget and Financial Considerations

Cutler, I. (1995). *The role of finance reform in comprehensive service initiatives.* Washington, DC: The Finance Project.
This paper examines the strategies for financing a variety of community-based comprehensive initiatives across the country, with special attention to their applicability to major systems change. It highlights a number of issues that decision makers will have to address in their efforts to successfully create comprehensive systems that link education and other children's services and strengthen community supports outside the mainstream of categorical services. It highlights a number of issues to be considered as policymakers explore central finance questions.

Friedman, M. (1995). *From outcomes to budgets: An approach to outcomebased budgeting for family and children's services. Manuscript in preparation.* Washington, DC: Center for the Study of Social Policy.
This paper argues that changes to budgeting systems are essential for effective reform in family and children's services. It discusses the problems with current budget systems, sets forth some basic definitions and concepts about outcomesbased budgeting, provides a framework for an outcomes-based budgeting process, and examines some of the issues associated with developing such a budgeting approach. The appendices give examples of outcomes, outlines an approach to implementing outcomes-based budgeting, and provides an example of an outcomes-based budget agenda. This paper provides useful information for states and localities on a critical area of accountability.

Government Finance Officers Association (2005). *First 5 Financial Management Guide* and *Financial Management Tool Ki at www.f5ac.org*.

The purpose of the Guide is to help county commissions establish and refine their financial management policies and practices. The Guide contains best practices, standard practices, and in some instances, emerging practices in governmental finance. The policies and procedures included in the Guide have been tailored where possible to the specific needs and environment of First 5 commissions.

INTRODUCTION TO FOCUS AREAS

INTRODUCTION

Increased awareness about the importance of the early childhood period and its unique opportunities for effective support and/or intervention, combined with the funding afforded by this Act, provide communities with the opportunity to move forward in developing systematic efforts to improve the lives and futures of young children. However, it is very hard to find authoritative guidance from traditional research practices about taking the many pieces of "what works" from the domains of prenatal care, child health, early childhood, preschool education, child care and development, family support, parent education and community building, and combining them into a coherent whole that can be sustained over time. Moreover, much of the success of "what works" depends upon the care with which strategies are chosen and applied to the circumstances of the communities and families involved.

Nevertheless, the experiences of many communities and practitioners offer rich suggestions for achieving the strategic results provided for in the Act and envisioned in these guidelines. County Commissions do not need to start from scratch to figure out what they consider the most plausible links and pathways that connect programs and strategies to interim and long-term results or outcomes for young children and their families. The purpose of this section is to provide local planners with a compendium of strategies that may be effective in achieving major agreed-upon outcomes and strategic results.

The Act specifically requires the State Commission guidelines to address, at a minimum, "parental education and support services"; "the availability and provision of high quality, accessible, affordable child care"; and "the provision of child health care services". The following program sections focus on suggested goals, strategies and planning consideration for achieving those goals. The areas of concentration suggested (e.g., "Support for High-Quality Child Care Programs" or "Educating Families for Healthy Pregnancies and Newborns") are either required by the Act to be included in the guidelines, or they are recommended for consideration by the Guidelines Advisory Committee. The areas of concentration and objectives for consideration suggested in the "Health and Wellness" section were drawn from the Draft Healthy People 2010 Objectives, developed by the U.S. Department of Health and Human Services, because they are generally considered to represent the desirable and appropriate standards for health care.

Several caveats are in order when reviewing this part of the guidelines. First, while the

resources made available to County Commissions under the Children and Families Act are significant, they are not adequate to address all of the needs County Commissions will identify. Nor are they adequate to cover all the suggested goals and strategies contained in these guidelines. Instead, the Act offers County Commissions the opportunity to mobilize communities around critical issues affecting young children and their families and to identify approaches that begin to meet their highest needs. Also, the strategies chosen will vary greatly from county to county, at least in part because of vastly differing needs and resources. Commissioners in small counties will receive modest funds and therefore will be more restricted in what they can do. Adopting strategies that focus on a more limited or targeted set of outcomes would be appropriate to consider in these cases.

Second, while the sections that follow are organized around discrete program areas (as required in the Act), the Act also encourages "an integrated, comprehensive, and collaborative system of information and services to enhance optimal early childhood development." Efforts have been made to show points of cross-reference; some are apparent through the obvious overlap and repetition of goals, objectives, strategies and outcomes. County Commissions may want to consider a combination of new and integrated approaches to enhance early childhood development that blend service delivery and community-building strategies and build on collaborative efforts that are already under way.

Additional guidance through regional workshops, written materials and research will be forthcoming from the State Commission, both in the short-term and over time.

FOCUS AREA ONE: PARENT EDUCATION AND SUPPORT SERVICES

STRATEGIC RESULT – IMPROVED FAMILY FUNCTIONING: STRONG FAMILIES

Parent support and family education programs are one of the best and most cost effective methods to promote children's success. The programs enable parents to become better teachers, role models, protectors, and providers. These programs can provide parents many forms of social support including:

- Support and guidance in child rearing.
- Models of effective forms of discipline and child management including positive forms of interacting and engaging children and models of a safe and secure environment for children.
- Introductions to other parents for activities that offer support and a sense of belonging.
- Access to information such as resources and referrals to other forms of community support.

- Introduction to concrete services, such as job skills.

- Emergency respite and drop-in services.

- Support for the emotional and physical health and well-being of the children.

Definitions Useful in Discussing Parent Education and Support

There are many terms used to describe efforts to provide education and support for parents. The following definitions may be useful:

- **Parent:** Anyone who carries the responsibility for raising a child. This can be a biological parent, a stepparent, an adoptive parent, a foster parent, a relative (e.g., grandparent), a sibling or another member of the child's extended family, or expectant fathers and pregnant mothers.

- **Parental Education:** Parent education are all used to describe efforts to provide parents with knowledge and skills directly related to parenting, and to assist families in becoming self-sufficient and providing safe, stable, loving and stimulating environments so that their children can thrive.

Parent Education and Support is most often based on an integrated service delivery model. The following are examples of integrated service delivery strategies that incorporate parent education and support:

- Family Resources Centers generally offer a broad spectrum of universally accessible, comprehensive community-based services, all intended to promote the well-being of families. Family Resource Centers can employ staff who work collaboratively with onsite and near site child care programs to extend family support and education services to families. Resources might also be provided to enhance the capacity of the child care programs to partner with families to provide onsite, parent-driven activities and to participate in Family Resource Center-sponsored activities.

- Pediatric nurse practitioners and/or family advocates, based in community organizations to work directly with young parents through a combination of home visiting and center-based approaches. They work in multi-disciplinary teams, working with families being served by the mental health, health and child care disciplines.

- Family Prevention Specialists, housed in child care resource and referral agencies or early childhood agencies, offer informal support and linkages to formal support services for families being served in family child care homes. They also provide support to family child care providers through regular visits and parenting education workshops.

- School-based family literacy programs incorporate family support components, establishing linkages with onsite or near-site early childhood programs.

In developing strategies to address the needs of families for high-quality services, County Commissions may consider these three interrelated areas of concentration:

1. Education and Family Support for Pregnancy and Newborns
2. Education and Family Support to Enhance Parenting and Child Development
3. Support for Family Stability and Well-being

The intent of the Children and Families Act is to promote the delivery of these services in a consumer-friendly, integrated and coordinated manner. The continuum of family/parent support encompasses a broad spectrum of support ranging from parent education, child development, health, family self-sufficiency and substance abuse prevention and treatment for at-risk families. Integrated, comprehensive service systems will utilize strategies that create unique approaches to serve target populations and individual needs. This section closes with planning considerations to support an integrated, family-friendly approach.

EDUCATION AND FAMILY SUPPORT FOR PREGNANCY AND NEWBORNS

Goal

To prepare prospective parents of newborns for the demands of parenting through educational programs.

There are a number of areas that are essential for educating families for healthy pregnancy and newborns. Our knowledge of the effect of maternal health behaviors on fetal development has made it clear that parenting begins before birth. Important gains in fetal health are made by preparing parents both practically and psychologically for caring for a newborn. Many new parents today have little idea of what to expect from a newborn and may not be adequately prepared to recognize the breadth of their child's needs.

A. Early Parent Education

Background

In addition to promoting healthy pregnancies, early parent education is an important tool for:

- Educating and training parents in childbirth and newborn and infant health care (birth classes and post-natal classes), including breastfeeding.
- Teaching nurturing skills for optimal infant development.
- Teaching parenting skills.
- Avoiding unintentional injuries.

- Educating pregnant mothers and their significant others on health risks of tobacco, illicit drugs, alcohol, other substances, and risky behavior that can harm the developing fetus, including the risk of infants born HIV positive.
- Educating parents, especially farmworkers, about the dangers of agricultural pesticides and their impact on developing fetuses, newborns, and young children.
- Preventing child abuse and neglect.

Many groups provide parenting education, including public health programs, Family Resource Centers, natural childbirth groups, community-based prevention programs, and mental health services. Mutual support and self-help groups also provide a network of support to members in adjusting to new roles, problems, or changes in family circumstances. These groups can help members expand their social contacts, improve their feelings of self-esteem, and increase their knowledge of child development.

Strategies for Consideration

- Create a resource list of all early parent education programs, including qualifications of staff, and distribute it broadly.
- Work with local child and health care providers, social service and community-based organizations, and agencies to promote the provisions of information on:

  - The importance of regular, preventive pediatric health care;
  - Newborn nutritional needs and feeding practices;
  - Information on the health advantages of breastfeeding;
  - Information on safety and unintentional injuries;
  - The importance of nurturing, stimulating environments for very young children;
  - Information on managing and disciplining young children.

- Agree on and identify risk indicators relevant for children prenatally and after birth.
- Identify areas of county with high incidence of early risk.
- Locate Family Resource Centers in neighborhoods where there is a high incidence of early risk. Family Resource Centers can provide early parent educational programs, as well as link families to needed resources.
- Increase the range of sites for parenting education including work sites, local libraries, faith-based centers, PTA meetings, hospitals, etc.

- Recruit fathers: Consider changes in the content and approach of parent education programs to address issues relevant to fathers in health, welfare, and social service programs and optimize opportunities to seek meaningful contact with their children.
- Collaborate with or establish home visiting programs.

B. Early Prenatal Care

Background

Early prenatal care has long been considered the single most effective and cost-effective intervention for improving infant health. Comprehensive prenatal education programs are important channels for disseminating information about prenatal nutrition, the effects of prenatal substance abuse, infant nutrition and breastfeeding, and postnatal care of a newborn. When women receive adequate early prenatal care they gain important medical information as well as ideas about preparing for their babies. Problems with the developing fetus may be detected and evolving parenting challenges can be discussed.

Strategies for Consideration

- Identify all of the prenatal programs in the county and identify the areas of the county having a high incidence of low birth weight and infant mortality.
- Use existing health clinics and collaborate with prenatal health providers to develop an outreach campaign to potential parents.

C. Prenatal Exposure To Substance Abuse (Tobacco, Alcohol, and Illicit Drugs)

Background

The effects of substance abuse during pregnancy have been well documented. Prenatal exposure to tobacco, alcohol and illicit drugs increases a child's risk of mental retardation, neuro-developmental deficits, attention deficit disorders with hyperactivity, fine-motor impairment, as well as more subtle delays in motor performance and speech. Maternal smoking and infant exposure to environmental tobacco smoke has been linked to asthma, low birth-weight and an increased risk of Sudden Infant Death Syndrome (SIDS).

Strategies for Consideration

- Increase the information and fact sheets on the harmful effects of illicit drugs, alcohol and tobacco to reach all pregnant and parenting families.
- Identify who in your community is responsible for coordinating educational services for substance abusing families.
- Identify the number of beds in substance abuse treatment programs available for pregnant women in your county.

- Identify and increase the number of residential programs for women and their children.
- Increase the use of community-based programs for outreach and referral.
- Identify the number of training classes offered to caregivers of prenatally exposed children in your community.
- Collaborate or establish home visiting programs.

D. Nutrition Education Issues

Background

Research has shown that inadequate nutrition and weight gain during pregnancy can increase the risk of low birth-weight infants, which is associated with increased risk of hearing, vision, or learning problems, and an increased need for special education. Specific nutritional deficiencies, most notably folic acid, increase the risk of neural tube defects (e.g., anencephaly, spina bifida) that may lead to serious impairment or death.

Good nutrition and physical activity can promote social and cognitive development of young children, and improve children's readiness to learn. The Child and Adult Care Food Program operates with 175,000 family child care home providers to offer high-quality nutrition and nutrition education for families and children.

Strategies for Consideration

- Assess the nutrition information available to all pregnant women through public health programs, private non-profit health programs, managed care programs and through public schools.
- Implement free, accessible, language appropriate nutritional educational programs for pregnant women including current information on the effect of poor nutrition on the developing fetus.
- Improve coordination with the WIC program (the Special Supplemental Food Program for Women, Infants and Children) and utilize their parent education programs that extend beyond nutritional needs to include early parenting skill-building and proper postnatal care practices.
- Leverage matching federal funds with USDA to target lowincome families to promote nutrition education/physical activity. Develop special Local Incentive Awards Programs that would enable County Commissions to qualify for USDA matching funds.
- Assist with training and technical assistance regarding culturally relevant, age-appropriate nutrition education activities that help children acquire the knowledge and skills they need to make lifelong healthy eating and physical activity choices.
- Advance the adoption and expansion of model programs with strong nutritional/physical activity components, such as Head Start and Migrant Education.

- Provide access to a network of partners that are promoting environmental and systems changes to improve the health of low-income families with children.
- Increase the number of Child and Adult Care Food Program providers in an area.

EDUCATION AND FAMILY SUPPORT TO ENHANCE PARENTING AND CHILD DEVELOPMENT

Goal

To enable parents to utilize multi-disciplinary parenting education resources to increase their capacity and confidence to raise healthy children.

A. Parenting Education

Background

Parenting education is designed to increase caregivers' capacity and confidence in raising healthy children. It assumes that parenting is a learned skill and that all parents have strengths and the ability to be good parents. It also assumes that every child and every parent is different and there are no "quick fixes." As a family support activity, parent education is family-focused and family-centered, strengths-based, resource-based, culturally competent and designed to empower families.

Cultural diversity is a California strength. Counties in California have some of the richest collections of multi-cultural families in the world. They have much to contribute concerning alternate methods of parenting and much to learn from new concepts in child development. A family-focused parenting education program should strive to respect and embrace differences.

Parent education classes are provided through a variety of institutions including school districts, Family Resource Centers, hospitals, community colleges, faith-based sites and community-based nonprofit organizations. Programs may range from a single lecture presentation to a series of classes and support groups that may involve discussion or other activities.

Parenting education generally crosses four specific disciplines: education, health, human services and mental health. Although these disciplines have different languages and conceptual frameworks, parenting education emphasizes the following core competencies:

- Understanding child development (ages and stages).
- Setting limits/effective discipline.
- Building self-esteem and parenting confidence.
- Understanding the relationship between physical and emotional health.

- Learning communication skills with children during different stages of development.
- Understanding the various stages of parenthood.
- Learning how to advocate for your child.
- Balancing work and family.
- Learning how family discord/harmony affects young children's stability.
- Understanding family systems and functioning.
- Understanding transitions in the family.
- Practicing conflict resolution.
- Learning parent advocacy and parent empowerment.

Strategies for Consideration

- Itemize the number, type and qualifications of parenting education programs available to parents by neighborhood or community and increase the number of parenting education
- programs in geographic areas not currently being served.
- Expand home-based programs to educate new parents on child development and family life skills.
- Extend evening parenting programs.
- Develop telephone support or "warm lines."
- Extend resources for peer support, group support, group therapy and individual therapy.
- Enlist local employers in providing space and other support for parenting classes and time off for employees to attend.
- Provide professional training workshops to prepare local service providers and caregivers to deliver research-based programs.

B. Education to Enhance Child Development

Background

Parent education programs in all disciplines attempt to help parents raise healthy children. Child care programs often provide for education on child development; parents may also get this information through health providers, social workers, community colleges or community-based social service programs.

Key to child development education is an understanding of the developmental stages a child passes through in infancy through adolescence, in order for parents to have realistic expectations of their children. Cultural sensitivity is

especially important in the area of child development as the many cultures represented in California have
varying methods of rearing their children. Understanding child development:

- Enables parents to support their children through different stages.
- Helps parents understand the varying and conflicting types of temperament their children are born with.
- Enables parents to develop more confidence in raising their children.

Outreach to parents in their homes is particularly important for at-risk and isolated families. A growing body of research shows that family support programs must focus on the family, rather than simply the child; on prevention, rather than intervention or treatment; and on family empowerment. Family support programs must be designed to strengthen and enhance the growth and development of the entire family unit, and focus on empowering adults in their roles as parents, nurturers and providers.

Specifically, parenting education should include training for the care of children with special care needs (e.g., children who were drug exposed, have fetal alcohol syndrome or have other developmental disabilities).

Strategies for Consideration

- Itemize the number and type of child development education programs available to parents by neighborhood or community and increase the number of child development education programs in areas not served.
- Increase child development education through health providers, clinics, community colleges, Family Resource Centers, home visiting or mentoring programs.
- Utilize parent participation preschools such as Head Start and parent cooperative nursery schools as non-intrusive forms of “hands-on” child development education.
- Develop parent advocacy groups in neighborhoods to oversee the parenting programs available.
- Collaborate with or establish home visiting programs.
- Encourage the development of bilingual programs in child care and development programs for limited English proficient and monolingual children.
- Encourage the development of parent and provider training in identifying young children with learning disabilities and emotional and behavioral disorders.

C. Education of Teen Parents on Parenting and Child Development

Background

In California in 1995 there were 68,409 babies born to women under 20. While 59.8 percent of these babies were born to women between 18 and 20, many of the teens were still high school age (38.8 percent were born to women 15 to 18 years old) and 2.4 percent of babies were born to children under 15 (in high school and junior high). While the number of very young teens who give birth is low, they are at an increased risk for high school drop out and delivering low birth-weight babies.

In general, infants born to teen parents have a higher rate of accidental death due to causes such as burns, suffocation, car accidents and injuries during the first year of life compared to infants with parents over age 20. These fatalities likely represent the most extreme tip of the iceberg in terms of the challenges adolescents face in caring for their infants. Although young children of adolescents have only slightly lower scores on developmental assessments, difficulties began to emerge in terms of school success as they grow older.

Strategies for Consideration

- Identify the high risk indicators for teen parenting by neighborhood.
- Increase prenatal services for adolescent parents.
- Increase programs for teen fathers.
- Assess the number of child development classes available to teen parents.
- Consider increasing the number of teen clinics located near or in public high schools.
- Encourage high schools to provide high-quality onsite child care programs.
- Increase the outreach for CalWORKS and Adolescent Family Life programs for teens.

D. Family Literacy Programs

Background

Becoming literate improves the learning environment of the home and the employability of the parent. Helping low-literate adults improve their basic skills has a direct and measurable impact on both the education and quality of life of their children. When education and other background factors are held constant, adult literacy is strongly
associated with a range of important economic and social outcomes (e.g., employment, wages, poverty). As the education level of adults improves, so does

their children's success in school. Family literacy programs provide many opportunities to build on connections between parenting and other adult roles and skills.

Key features of popular family literacy services include:

- Helping families during the children's infancy by encouraging language development and interactive play as precursors to emergent literacy.
- Providing books, print materials and lessons that are appropriate for the literacy levels of family members.
- Providing parenting education.

Strategies for Consideration

- Support family literacy opportunities in multiple settings: child care centers, Head Start, family child care networks, community-based organizations, libraries and parent resource centers.
- Contact libraries, universities, community colleges, volunteer agencies and retired individuals for literacy tutors.
- Utilize concepts of family literacy programs to provide in home literacy support in home-based child care.
- Work with grandparents, volunteers and other caregivers of young children to increase their literacy and use of books.

SUPPORT FOR FAMILIES' STABILITY AND WELL-BEING

Goal

To support families of young children in their efforts to become economically, socially and emotionally self-sufficient.

A. Develop and Support an Integrated System of Services to Enhance and Maintain Family Self-Sufficiency

Background

There are social and emotionally challenges to self-sufficiency. While parent education can be used to increase parents' knowledge, to change attitudes and to build skills, without changes in the social and economic environments in which families live, education may have a limited impact on parenting behaviors and child outcomes.

Providing nurturing and stimulating environments for children is a challenge for parents facing financial insecurity and poverty; physical or social isolation; housing instability, unavailability or overcrowding; and community or domestic violence.

Family support centers and programs are being increasingly utilized as "one stop shops" for an array of services, including:

- Adult education, vocational education and job training.
- Assistance with housing.
- Assistance with other basic needs to help parents balance work, family and self.
- Emotional support and peer guidance from others who have succeeded.
- Parenting education.
- Referrals to service agencies, such as health clinics.

Strategies for Consideration

- Support the development of Family Resource Centers or family resource mobile vans.
- Create a comprehensive guide of all public and private education programs for adults.
- Encourage agencies to create neighborhood-based education programs for adults that are easily accessible to families with young children.
- Provide affordable, accessible, flexible child care at sites providing education for adults.

- Support the development of neighborhood-based groups.

Goal
To develop multi-disciplinary intervention and treatment services that enable parents to overcome risk and danger in their homes and in their communities, to keep children safe, provide them with permanent homes and ensure their optimal well-being.

B. Prevention and Intervention Programs for Families with Young Children Who are at Risk of Abuse and Neglect

Background

Most families function successfully under everyday circumstances. However, children living in families with four or more of the following characteristics may be considered at "high risk":

- Child is not living with two parents.
- Household head is high school dropout.
- Family income is below the poverty line.
- Child is living with parent(s) who do not have steady, full-time employment.
- Family is receiving welfare benefits.
- Child does not have health insurance.

In 1996, 17 percent of California children lived in "high risk" families, based on the above definition, as opposed to 14 percent nationally (Child Trends, May 1999). Families under these impoverished, stressful circumstances may be more likely to neglect their children educationally, medically and emotionally due to a lack of basic services.

However, the incidence of child abuse cuts across all economic lines. Parenting education, emotional support and basic health and employment services offered in community-based family support programs may be helpful in addressing the challenges faced by all families.

Domestic violence clearly affects the well-being of young children:

The estimated overlap between domestic violence and child physical or sexual abuse ranges from 30 to 50 percent. Some shelters report that the first reason many battered women give for fleeing the home is that the perpetrator was also attacking the children.

Children can experience serious emotional damage as a result of living in a violent household. Children exposed to family or neighborhood violence are at

higher risk for developing anxiety, sleep disturbances, poor school performance, delinquency,
aggression and suicide, than children who grow up in safe environments. Child witnesses to domestic violence should themselves be considered abused.

Substance abuse also affects the caregiving of young children:

- An estimated 10 to 25 percent of American children live with an alcoholic parent. Studies have found that these children are at greater risk for developing emotional, social, behavioral and academic problems than are children of non-alcoholic parents.
- Mental illness and substance abuse are related. A very small number of families have parents who are seriously mentally ill, and abuse and neglect their children as a part of their problem. The use of substances in conjunction with a mental health problem such as depression or schizophrenia may increase the child's risk.

Intervention programs for families in serious crisis are mandated by federal law and usually provided by county child welfare workers if the child is reported for child maltreatment services. They are traditionally family-focused and provide an array of integrated services using the capabilities of child welfare, mental health, substance abuse, health, probation and education (early childhood education).

Strategies for Consideration

- Develop or identify integrated, cross trained service teams of social workers, health workers, early childhood workers, mental health workers, job developers, CalWORKS workers, home visitors and community workers.
- Develop programs that involve the family's network, such as Family Group Decision Making (Family Conferencing).
- Involve the "faith community" in neighborhood-based interventions such as family mentoring, family assessment centers, and Family Resource Centers.
- Provide outreach and special focus for young families at community-wide events and fairs.
- Expand family-friendly support groups, especially for socially or geographically isolated families.
- Work with other agencies to create telephone hotlines (or "warm lines") to provide 24-hour support, information and referrals to stressed parents to prevent child abuse and neglect and to provide information and referrals to others concerned about child abuse.

C. Expand Programs for Young Children in Out-of-Home Care with Kin or Foster Parents

Background

California has approximately 113,000 children in out-of-home care in our child welfare system – 20 percent of the total number of children in out-of-home care nationally. Approximately 25 percent of these children are under 5 years of age and are living with relatives or foster parents.

Characteristics of Children in Out-of Home Care (June 2006)

Total Children = 85,204

Ethnicity		
Black	24,728	29%
Hispanic	32,617	38%
White	23,801	28%
American Indian/ Alaskan Native	1,568	2%
Asian /Pacific Islander	2,490	3%

Many relatives and foster parents are older, working adults. Frequently, a kin-caregiver is the 70-year-old great-great grandmother of a very young child. Caring for very young children can be stressful under normal circumstances, but it is particularly difficult if the child has been damaged either by parental child abuse or neglect or by the child's experience in the child welfare system. To insure better outcomes for maltreated children, their caregivers need support through peer groups, professional counseling, respite child care and ongoing child care.

Many very young children in the child welfare system have been doubly damaged by their experiences at home and by the stress of the child welfare system. Multiple moves between caregivers can have significant affect on a child's ability to normally attach. Very young children need early psychological as well as medical assessments to
quickly provide needed interventions. Many children in the child welfare system, who are not formally diagnosed developmentally disabled or mentally ill, may still need specialized therapeutic child care to help them with their educational challenges, emotional growth and behavior management.

Strategies for Consideration

- Expand quality child care for children in the child welfare system.
- Expand respite care.

- Expand mental health consultation services for very young children who are at home, in child care, with relatives or in foster care.
- Expand training for foster parents and grandparents in caring for and supporting children with disabilities.

CREATING A CONSUMER-ORIENTED DELIVERY SYSTEM AND OVERALL PLANNING CONSIDERATIONS

With such diversity within the field of family support and parental education, it is even more critical that communities, and particularly the voices of parents, have weight in determining the approaches to be utilized in each community. Giving voice to a range of perspectives during the planning stage ensures that critical information or viewpoints are not left out of program design. This will also engender support from a broad array of constituents. Involving parents makes them feel valuable, creates a sense of ownership over the programs and the desire to participate once programs and services are in lace.

A key strategy has been to focus on the power of neighborhood resources – natural entry points that have a potential to serve children and families. For young families this might mean Family Resource Centers, libraries, Head Start, child care centers and recreation program. These primary services have roots in communities and informal ways of relating that are natural and often enjoyable. These services have the flexibility to be responsive to cultural preferences and values. Because they are voluntary, they offer families a sense of choice and control and generally work in ways that are neither categorical or stigmatizing. In creating a consumer-oriented service delivery system, these primary services play a key function as part of the needed infrastructure for family services, uniting services that enhance functioning and development as partners with specialized services that respond to child and family problems.

Planning Considerations

County Commissions may want to consider the following planning questions in developing strategies to promote parent education and support programs.

- All programs targeted to young children affect the conditions of families. Does the plan infuse relevant parenting education and support into the broad range of social supports that exist or will be developed in the community?
- Does the plan establish/strengthen linkages among agencies, organizations and individuals to promote effective patenting and public awareness of the importance of families in California?
- Does the plan ensure that a continuum of care for families is developed, offering a range of intervention, prevention and promotion efforts?
- Does the delivery of parent education and support programs build upon the systems that serve as natural access points for young families? Are the

services easily accessible and located in close proximity of the families to be served?

- Does the plan have input from potential participants of the programs and services to be delivered? Will parents have an impact on program implementation? If so, will they feel this impact? Do the options facilitate a reciprocal relationship between parents and programs?
- Does the plan address child care and transportation issues that support family participation?
- Providing a range of participation options for parents, from receiving services to board membership, facilitates reciprocal relationships with parents and allows them to contribute on multiple levels. Do the programs involve parents in a variety of roles?
- Are the programs and services to be developed and information to be disseminated responsive to and respectful of the cultural context in which families live and raise their children?
- Are the Parent Education and Support programs and services based on clearly
- articulated theories of child development, parent development and other theories?
- Do programs acknowledge that while all parents have the ability to be good parents, parenting is a learned skill, and healthy parenting is developed over time?
- Do programs focus on building and strengthening informal support networks for families rather than depend solely on professional support systems?
- Are programs flexible and continually build on the unique strengths as well as
- identified needs of each family and community?
- Do programs affirm and strengthen families' cultural, racial and linguistic identities and enhance their ability to function in a multicultural society?
- Do programs facilitate parental involvement and build parents' capacity to serve as a resource to other parents, participate in program decisions and governance, and develop the ability to advocate on behalf of their community?

NOTE: A source for more in-depth information about this community strategy is the American Youth Policy Forum, Education and Human Services Consortium monograph, *Children, Families and Communities: Early Lessons from a New Approach to Social Services* (Washington, DC, 1995).

REFERENCES

The following list of references is taken from ZERO TO THREE, National Center for Infants, Toddlers and Families.

ZERO TO THREE's mission is to advance the healthy development of babies and young children. We focus on the first three years of life because this is the time of greatest human growth and development. It is also the time when caring adults have the greatest opportunity to shape a child's future.

We work to strengthen the critical roles of professionals, policymakers and parents in giving all of our children the best possible start. We do this through training, technical assistance, research and dissemination.

If you are worried about your child's development and would like to request an evaluation, please contact your state's Central Directory Office to locate the resources in your state or jurisdiction. Contact information can be obtained from the National Early Childhood Technical Assistance System (NECTAS) Web site at http://www.nectas.unc.edu./makecx/cendir.html

The following resource list is intended to help parents, professionals and policymakers meet specific needs which surpass **ZERO TO THREE**'s scope. While we have suggested you contact these organizations for additional information, **ZERO TO THREE** in no way can verify the accuracy of their information.

Brain Development

I Am Your Child Campaign
335 N. Maple Drive, Suite 135
Beverly Hills, CA 90210
(310) 285-2385
http://iamyourchild.org

Families and Work Institute (Publication*: Rethinking the Brain*)
330 Seventh Avenue, 14th Floor
New York, NY 10001
(212) 465-2044
(212) 465-8637 (fax)
http://www.familiesandwork.org

The Ounce of Prevention Fund (Resource paper: *Starting Smart*)
122 S. Michigan Avenue
Chicago, IL 60607
(312) 922-3863
http://www.bcm.tmc.edu/civitas/links/ounce.html

Breastfeeding

Breastfeeding Support Network **(for breastfeeding supplies only)**

2028 W. 9th Avenue
Oshkosh, WI 54904
(920) 231-1161
(888) MOMS-BAGS
(888) 666-7224
(920) 231-1697 (fax)
http://www.momsbags.com/index.html

Lactation Associates/National Alliance for Breastfeeding Advocacy
254 Conant Road
Weston, VA 02193-1756
(781) 893-3553
(781) 893-8608 (fax)
http://members.aol.com/marshalact/lactationassociates/

La Leche League International
1400 N. Meacham Road
Schaumburg, IL 60173-4048
(847) 519-7730
(800) LA LECHE
http://www.lalecheleague.org

Child Abuse and Neglect
(See also Violence Prevention, Child Welfare)
National Center on Child Abuse & Neglect (NCCAN):
National Clearinghouse on Child Abuse & Neglect Information
330 C Street, S.W.
Washington, DC 20447
(703) 385-7565
(800) 394-3366
(703) 385-3206 (fax)
http://www.calib.com/nccanch

NCCAN Prevention Program Database (provides detailed information on current child abuse and neglect programs throughout the country)
http://www.calib.com/nccanch/database

The Kempe Children's Center
(Formerly the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect)
1825 Marion Street
Denver, CO 80218
(303) 864-5252
(303) 864-5179 (fax)
http://kempecenter.org

National Committee to Prevent Child Abuse
200 S. Michigan Avenue, 17th Floor

Chicago, IL 60604
(312) 663-3520
http://www.childabuse.org

American Humane Association Children's Division
(Formerly the National Resource Center on Child Abuse and Neglect)
63 Inverness Drive E.
Englewood, CO 80112-5117
(303) 792-9900
(800) 227-5242
http://www.americanhumane.org/cpmain.html

National Survivors of Childhood Abuse Program:
Child Help National Child Abuse Hotline
15757 N. 78th Street
Scottsdale, AZ 85260
(480) 922-8212
(480) 922-7061 (fax)
(800) 4-A-CHILD
(800) 2-A-CHILD (TDD-hearing impaired)
http://www.childhelpusa.org

Parents United San Jose Chapter, Giaretto Institute (sexual abuse)
232 E. Gish Road
San Jose, CA 95112
(408) 453-7616
http://www.localink.net/sjpu/

Child Care Information
Accreditation/Licensing:
National Association for the Education of Young Children (NAEYC)
1509 16th Street, N.W.
Washington, DC 20036
(202) 232-8777
(800) 424-2460
http://www.naeyc.org

Child Development Associate (CDA) Certificate:
Council for Early Childhood Professional Recognition
2460 16th Street, N.W.
Washington, DC 20009-3575
(202) 265-9090
(800) 424-4310
(202) 265-9161 (fax)
http://www.cdacouncil.org/

Family Child Care: *(For parents looking for an accredited home or providers seeking training)*

National Association for Family Child Care
525 S.W. 5th Street, Suite A
Des Moines, IA 50309-4501
(515) 282-8192
(515) 282-9177 (fax)
http://www.nafcc.org

General Information:
National Child Care Information Center
(800) 616-2242
http://www.nccic.org

National Resource Center for Health and Safety in Child Care
Colorado School of Nursing
Health Sciences Center
4200 E. 9th Avenue
Campus Box 287
Denver, CO 80262
(800) 598-5437
(303) 315-5215 (fax)
http://nrc.uchsc.edu

Early Head Start/Head Start:
Early Head Start National Resource Center
734 15th Street, N.W., Suite 1000
Washington, DC 20005-1013
(202) 638-1144
(202) 638-0851 (fax)
http://www.ehsnrc.org

National Head Start Association
1651 Prince Street
Alexandria, Virginia 22314
(703) 739-0875
http://www.nhsa.org

Legal Information:
Child Care Law Center
973 Market Street, Suite 550
San Francisco, CA 94103
(415) 495-5498
(415) 495-6734 (fax)
http://www.childcarelaw.com

Resource & Referral Agencies:
Child Care Aware
1319 F Street, N.W., Suite 810
Washington, DC 20004

(800) 424-2246
http://www.childcarerr.org/childcareaware/index.htm

National Association of Child Care Resource & Referral Agencies (NACCRRA)
1319 F Street, N.W., Suite 810
Washington, DC 20004-1106
(202) 393-5501
(202) 393-1109 (fax)
(800) 570-4543
http://www.naccrra.net

Child Safety
(See also Child Care for the National Resource Center for Health and Safety in Child Care)
Consumer Products Safety Commission
Washington, DC 20207
(800) 638-2772
(800) 638-8270 (Hearing Imparied)
http://www.cpsc.gov

American Academy of Pediatrics
141 N.W. Point Blvd.
Elk Grove Village, IL 60007-1098
(847) 228-5005
(847) 228-5097 (fax)
(800) 433-9016
http://www.aap.org

National SAFE KIDS Campaign
1301 Pennsylvania Avenue, N.W., Suite 1000
Washington, DC 20004
(202) 662-0600
(202) 393-2072 (fax)
http://www.safekids.org

Child Welfare
The following Resource Centers are sponsored by the Children's Bureau, Administration on Children, Youth and Families, Department of Health and Human Services.

ARCH National Center for Respite and Crisis Care Services
The Chapel Hill Training-Outreach Project
800 Eastowne Drive, Suite 105
Chapel Hill, NC 27514
(919) 490-5577
(800) 473-1797
http://www.chtop.com/archbroc.htm

National Abandoned Infants Assistance Resource Center
Family Welfare Research Group
School of Social Welfare
University of California-Berkeley
1950 Addison Street, Suite 104
Berkley, CA 94704-1182
(510) 643-7020
(510) 643-7019 (fax)
http://cssr21.socwel.berkeley.edu/aiarc/index.htm

National Resource Center for Child Maltreatment (NRCCM)
1349 Peachtree Street N.E., Suite 900
Atlanta, GA 30309
(404) 881-0707
(404) 876-7949 (fax)
http://www.gocwi.org/nrccm/index.htm

National Child Welfare Resource Center for Organizational Improvement
Edmund S. Muskie Institute
University of Southern Maine
One Post Office Square
P.O. Box 15010
Portland, ME 04112
(207) 780-5810
(207) 780-5817
(800) HELP KID
http://www.muskie.usm.maine.edu/helpkids/

National Resource Center for Family Centered Practice
University of Iowa
School of Social Work
112 North Hall
Iowa City, IA 52242
(319) 335-2200
http://www.uiowa.edu/~nrcfcp/new/index.html

National Resource Center on Legal and Court Issues
ABA Center on Children and the Law
740 15th Street, N.W., 9th Floor
Washington, DC 20005
(202) 662-1720
http://www.abanet.org/child

National Resource Center for Permanency Planning
Hunter College School of Social Work
129 E. 79th St., Room 801
New York, NY 10021
(212) 452-7053

(212) 452-7051 (fax)
http://www.hunter.cuny.edu/socwork/nrcppabf.html

National Resource Center for Special Needs Adoption/Spaulding for Children
16250 Northland Drive, Suite 120
Southfield, MI 48075
(248) 443-7080
(248) 443-7099 (fax)
http://www.spaulding.org

National Resource Center for Youth Services
The University of Oklahoma
College of Continuing Education
202 W. 8th St.
Tulsa, OK 74119
(918) 585-2986
http://www.nrcys.ou.edu

Cultural Diversity
Culturally and Linguistically Appropriate Services (CLAS)
Early Childhood Research Institute
University of Illinois at Urbana-Champaign
61 Children's Research Center
51 Gerty Drive
Champaign, IL 61820-7498
(800) 583-4135 (voice/tty)
(217) 244-7732
http://www.clas.uiuc.edu/

Maternal and Child Health National Center for Cultural Competence
3307 M Street, N.W., Suite 401
Washington, DC 20007
(202) 687-8635
http://www.dml.georgetown.edu/depts/pediatrics/gucdc/index.html

Disability Resources
Americans with Disabilities Act (ADA)
451 Hungerford Drive, Suite 607
Rockville, MD 20850-4151
(800) 949-4232
http://www.adainfo.org

Attention Deficit/Hyperactivity Disorder (ADD)
ADD Warehouse (publications)
300 N.W. 70th Avenue, Suite 102
Plantation, FL 33317
(800) 233-9273
http://www.addwarehouse.com

General Information:
National Information Center for Children & Youth with Handicaps (NICHCY)
P.O. Box 1492
Washington, DC 20013
(800) 695-0285
http://www.nichcy.org

National Early Childhood Technical Assistance System (NECTAS)
500 Nations Bank Plaza
137 E. Franklin Street
Chapel Hill, NC 27514-3628
(919) 962-2001
http://www.nectas.unc.edu

Learning Disabilities:
The National Center for Learning Disabilities
381 Park Avenue S., Suite 1401
New York, NY 10016
(212) 545-7510
(888) 575-7373 (Toll free info and referral)
http://www.ncld.org

Coordinated Campaign for Learning Disabilities
1200 New York Avenue, N.W., Suite 300
Washington, DC 20005-1754
(888) 478-6463
http://www.ldonline.org

Parents with Disabilities:
Through the Looking Glass
2198 Sixth Street, Suite 1000
Berkeley, CA 94710
(800) 644-2666
http://www.lookingglass.org

Speech/Hearing/Language Concerns:
American Speech-Language-Hearing Association Helpline
10801 Rockville Pike
Rockville, MD 20852
(301) 897-5700 (voice)
(301) 897-0157 (tty)
(301) 571-0457 (fax)
(888) 321-ASHA
http://www.asha.org/

Additional Resource:
Council for Exceptional Children

1920 Association Drive
Reston, VA 20191
(703) 620-3660
http://www.cec.sped.org

Drug Exposure/Substance Abuse
National Organization on Fetal Alcohol Syndrome (NOFAS)
418 C Street, N.E.
Washington, DC 20002
(202) 785-4585
(800) 66NOFAS
http://www.nofas.org

Center for Substance Abuse Prevention/National Clearinghouse for Alcohol and Drug Information
5600 Fishers Lane, Rockwall II
Rockville, MD 20857
(800) 729-6686
http://www.health.org

Funding Resources
Corporate Information:
The Taft Group (Taft Corporate Giving Directory)
27500 Drake Road
Farmington Hills MI 48331-3535
(800) 877-8238
http://www.bpa.org/taft/

Federal Agency Resources:
Capital Publications, Inc. (Health Grants and Contracts Weekly, Education Daily, Federal Grants and Contracts Weekly)
7201 McKinney Circle
Frederick, MD 21704
(800) 655-5597
http://www.aspenpub.com

Department of Health and Human Services:
GrantsNet
200 Independence Avenue, S.W.
Washington, DC 20201
(877) 696-6775
http://www.os.dhhs.gov/progorg/grantsnet/index.html

Superintendent of Documents, U.S. Government Printing Office:
(Federal Register, Commerce Business Daily, Catalog of Federal Domestic Assistance, U.S. Government Manual)
P.O. Box 371954
Pittsburgh, PA 15250-7954

(202) 512-1800
(202) 512-1800
http://www.access.gpo.gov/su docs

Foundation Information:
The Foundation Center
79 Fifth Avenue
New York, NY 10003
(800) 424-9836
http://fdncenter.org

Rockefeller Brothers Fund
437 Madison Avenue, 37th Floor
New York, NY 10011-7001
(212) 812-4299
http://rbf.org/index.html

Health Care (Includes Maternal & Child Health)
American Academy of Pediatrics
41 N.W. Point Blvd.
P.O. Box 927
Elk Grove Village, IL 60009-0927
(847) 228-5005
http://www.aap.org

Association for the Care of Children's Health (ACCH)
19 Mantua Road
Mt. Royal, NJ 08061
(609) 224-1742
http://Look.net/ACCH

Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
(703) 356-1964
http://www.mnchc.org

National Association for Children's Hospitals & Related Institutions
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355
http://www.ncahri.org/index.html

National Center for Education in Maternal and Child Health
2000 15th Street N., Suite 701
Arlington, VA 22201-2617
(703) 524-7802
http://www.ncemch.org

National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133
(301) 565-4167
(800) 336-4797
(301) 984-4256 (fax)
http://www.nhic-nt.health.org/

Training/Community Health:
Bright Futures Project
NCEMCH
2000 15th Street N., Suite 701
Arlington, VA 22201-2617
(703) 524-7802
(703) 524-9335 (fax)
http://www.brightfutures.org

National Healthy Mothers/Healthy Babies Coalition
121 N. Washington Street, Suite 300
Alexandria, VA 22314
(703) 836-6110
(703) 836-3470 (fax)
http://www.hmhb.org/

Immunizations
American Academy of Pediatrics (AAP)
141 N.W. Point Blvd.
P.O. Box 927
Elk Grove Village, IL 60009-0927
(847) 228-5005
http://www.aap.org

Every Child by Two
P.O. Box 109
Arlington, VA 22210-0109
(202) 651-7226
http://www.ecbt.org

Immunizations Education & Action Committee (IEAC)
(Healthy Mothers/Healthy Babies)
Rosie McLaren, Project Director
121 N. Washington Street
Alexandria, VA 22314
(703) 836-6110
(703) 836-3470 (fax)
ieac@hmhb.org (e-mail address)
http://www.hmhb.org/Committees/IEAC/ieac.html

Infant Massage
International Association of Infant Massage
U.S. Chapter
1891 Goodyear Avenue, Suite 622
Ventura, CA 93003
(800) 248-5432
http://www.IAIM.net/

Legal Assistance/Child Welfare Related
Child Care Law Center
973 Market Street, Suite 550
San Francisco, CA 94103
(415) 495-5498
http://www.childcarelaw.com

Youth Law Center/Children's Legal Protection Center
1325 G Street, N.W., Suite 7701
Washington, DC 20005
(202) 637-0377
(415) 543-3379
http://www.childprotect.org

Legal Assistance/Disabilities Related
American Bar Association Center on Children & the Law
740 15th Street, N.W.
Washington, DC 20005
(202) 662-1000
(202) 662-1720
http://www.abanet.org/child

Disability Rights Education and Defense Fund (DREDF)
Main Office:
2212 Sixth Street
Berkley, CA 94710
(510) 644-2555 (voice/tty)
(510) 841-8645 (fax)
Government Affairs:
1629 "K" Street N.W., Suite 802
Washington, DC 20006
(202) 986-0375
(202) 775-7465 (fax)
http://www.dredf.org/

National Association of Protection & Advocacy Systems
900 Second Street, N.E., Suite 211
Washington, DC 20002
(202) 408-9514 (voice)

(202) 408-9521 (tty)
http://www.protectionandadvocacy.com

National Center for Law and Deafness
800 Florida Avenue, N.E.
Washington, DC 20002
(202) 651-5373
Pike Institute on Law and Disability
Boston University School of Law
Boston, MA
(617) 353-2904 (voice/tty)
pikeinst@bu.edu (email)
http://www.bu.edu/pike/home.html

Parenting
Baby Center
539 Bryant, Suite 200
San Francisco, CA 94107
(415) 537-0900
http://www.babycenter.com

The Fatherhood Project
(212) 465-2044
http://www.fatherhoodproject.org

National Parent Information Center
University of Illinois at Urbana-Champaign
Children's Research Center
51 Gerty Drive
Champaign, IL 61820-7469
(217) 333-1386
(800) 583-4135 (voice/tty)
http://www.npin.org

Parents Place
jackie@iVillage.com or david@iVillage.com (email)
http://www.parentsplace.com

Poverty
(See also Public Policy)
National Center for Children in Poverty:
Columbia University School of Public Health
154 Haven Avenue
New York, NY 10032
(212) 304-7100
http://cpmcnet.columbia.edu/dept/nccp

Public Policy/Data/Advocacy
Center for the Future of Children
300 Second Street, Suite 200
Los Altos, CA 94022
(650) 948-7658
http://www.futureofchildren.org

Center on Fathers, Families and Public Policy*
20 North Wacker, Suite 1100
Chicago, IL 60606
(312) 341-0900
Children's Defense Fund
25 E Street, N.W.
Washington, DC 20001
(202) 628-8787
http://www.childrensdefense.org

Children's Health Fund
317 East 64th Street, N.W.
New York, NY 10021
(212) 535-9400
http://www.childrenshealthfund.org

Child Trends, Inc.
4301 Connecticut Avenue, N.W.
Washington, DC 20008
(202) 362-5580
http://childtrends.org

Child Welfare League of America
440 1st Street, N.W., Third Floor
Washington, DC 20001-2085
(202) 638-2952
http://www.cwla.org

National Association of Child Advocates
1522 K Street, N.W., Suite 600
Washington, DC 20005-1202
(202) 289-0777
http://www.childadvocacy.org

Health (includes insurance, Medicaid, financing):
Institute for Educational Leadership (includes the National Health/Education Consortium)
1001 Connecticut Avenue, N.W., Suite 310
Washington, DC 20036
(202) 822-8405
http://www.iel.org

Respite Care
Access to Respite Care & Help (by state)
(800) 773-5433
http://www.chtop.com/directory.htm

National Respite Coalition
4016 Oxford Street
Annandale, VA 22003
(703) 256-0541
(703) 256-9578 (Jill Kagan) or jbkagan@aol.com (email)
http://www.chtop.com/nrc.htm

Sudden Infant Death Syndrome (SIDS)
National Sudden Infant Death Syndrome Resource Center
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
(703) 821-8955
http://www.circsol.com/sids

Teen Pregnancy
Alan Guttmacher Institute
120 Wall Street
New York, NY 10005
(212) 248-1111
http://www.agi-usa.org

National Perinatal Association
3500 East Fletcher Avenue, Suite 209
Tampa, FL 33613-4712
(813) 971-1008
http://www.nationalperinatal.org

National Perinatal Information Center
One State Street, Suite 102
Providence, RI 02908
(401) 274-0650
http://www.npic.org

Violence Prevention
Center to Prevent Handgun Violence
1225 Eye Street, N.W., Suite 1100
Washington, DC 20005
(202) 289-7319
http://www.handguncontrol.org

Children's Safety Network - National Injury and Violence Prevention Resource Center
55 Chapel Street
Newton, MA 02458-1060
(703) 524-7802
(202) 466-0540
http://www.edc.org/HHD/csn

National Association for the Education of Young Children (NAEYC)
Violence Prevention Campaign
(202) 232-8777
(800) 424-2460
http://www.naeyc.org

National Coalition Against Domestic Violence
P.O. Box 18749
Denver, CO 80218-0749
(303) 638-6388
http://www.webmerchants.com.ncadv

National Coalition of Physicians Against Family Violence*
(312) 464-5066
http://www.ama-assn.org

Violence Prevention Database*
http://www.csnp.ohio-state.edu/glarrc.htm
http://www.npic.org

Volunteerism/Community Action
America's Promise
909 N. Washington Street, Suite 400
Alexandria, VA 22314-1556
(703) 684-4500
http://www.americaspromise.org

Connect for Kids
1634 Eye Street, N.W., 11th Floor
Washington, DC 20006
http://www.connectforkids.org

I Am Your Child
P.O. Box 15605
Beverly Hills, CA 90209
http://www.iamyourchild.org

*Where noted: information on addresses, phone number(s), web sites, etc. were not confirmed for accuracy.

ADDITIONAL REFERENCES

Smoking Cessation During Pregnancy

American Cancer Society, California Division
1710 Webster Street
Oakland, CA 94612
(800) ACS-2345
(510) 874-7161 (fax)
http://www2.cancer.org/state/ca/

Office on Smoking and Health
Centers for Disease Control and Prevention
Mail Stop K-50
4770 Buford Highway, N.E.
Atlanta, GA 30341-3724
(800) CDC-1311
(770) 332-2552 (fax)
http://www.cdc.gov/nccdphp/osh/

Smoke-Free Families, National Program Office
University of Alabama, Birmingham
Civitan International Research Center
1719 6th Avenue S., Suite 329
Birmingham, AL 35233-0021
(205) 975-8951
(205) 975-4411 (fax)

Exposure to Environmental Tobacco Smoke

American Lung Association of California
424 Pendleton Way
Oakland, CA 94621
(800) USA-LUNG
California Department of Health Services
Tobacco Control Section
Tobacco Education Clearinghouse of California
P.O. Box 1830
Santa Cruz, CA 95061-1830
(800) 258-9090
(831) 438-3618 (fax)
http://www.tecc.org/

AHCPR Guidelines: Health Systems Implementation
Agency for Health Care Policy and Research
P.O. Box 8547
Silver Spring, MD 20907
(800) 358-9295
http://www.ahcpr.gov/

Addressing Tobacco in Managed Care
National Technical Assistance Office
Health Alliance Plan
1 Ford Place, 5C
Detroit, MI 48202-3450
(313) 874-6821
(313) 874-6273 (fax)
http://www.aahp.org/atmc.htm

FOCUS AREA TWO: CHILD CARE AND EARLY EDUCATION

STRATEGIC RESULT – IMPROVED CHILD DEVELOPMENT: CHILDREN LEARNING AND READY FOR SCHOOL

Each California county is currently served by a number of public and private child care agencies which are responsible for planning, administering subsidy systems, offering resource and referral services to families and providers, and developing and providing child care and early education services to children and families. These include:

- State-funded child care resource and referral agencies
- Local child care planning councils
- School districts
- City and county child care coordinators
- County social services agencies
- School districts
- Adult education programs
- Child care centers with state contracts to serve low-income families
- Local interagency coordinating councils
- County child protective service agencies
- Alternative payment programs administering child care subsidies

These agencies may support County Commissions by providing information about existing services and needs. For example, counties are currently developing local child care needs assessments, which may inform local County Commissions in their strategic planning processes. Many of the agencies are in fact required by law to collect specific data. Coordination between County Commissions and these agencies may result in improvements regarding data collection and data capacity goals.

These guidelines are organized around suggested goals of improved ***quality, accessibility*** and ***affordability*** of child care and early education services: three interrelated core priorities or areas of concentration to consider for supporting creative,

strategic, integrated and comprehensive efforts to enhance the healthy development and economic well-being of California's children and families.

SUPPORT FOR HIGH-QUALITY CHILD CARE AND EARLY EDUCATION PROGRAMS

As child care needs continue to grow, communities face a growing dilemma: whether to devote resources primarily to *quantity* (namely, building the available child care supply to meet rising needs) or to *quality* (usually defined in terms of professional training and experience of caregivers, combined with staffing ratios and group sizes). In reality, these two cannot be separated, and staffing is the key. California, like the nation as a whole, is facing a severe staffing crisis in child care and early childhood education, with an estimated one in three teachers, providers or other caregivers leaving the job each year.

Child care is a very low wage field which has traditionally experienced high rates of job turnover. It has been particularly challenging to stabilize this work force at a time when California is experiencing a robust economic period of job growth and low unemployment. Regardless of their levels of education and training, many child care workers are now finding better-paying job options outside of this field. A sharp rise in the need for teachers due to class size reduction in the early elementary grades has motivated many of the best-trained child care staff to seek teaching jobs in public education. As a result, child care programs may find it difficult to recruit and retain the staff they need, or to meet the needs of the families they serve. Many child care programs are already operating below their licensed capacity, or even being forced to close their doors. Inevitably it is young children, dependent as they are on sensitive and consistent care, who are suffering the consequences the most.

In order to make child care and early education programs available and accessible to the families who need them – while keeping them affordable – communities may choose to devote considerable attention toward stabilizing and retaining the caregiving workforce. Training alone, however, is often insufficient. Although many child care workers are relatively well-educated, child care-related training is not widely linked to economic advancement, and as a result, many communities continually devote resources toward training new cohorts of caregivers because well-trained and educated workers, especially those with a BA degree or more, regularly leave the field for other employment.

Goal

Improve the quality of child care services that California children receive in order to promote optimal child development and school readiness, and family stability and economic independence.

Objectives, strategies and planning considerations for achieving child care quality are grouped below into three categories:

1. Training
2. Compensation and retention of providers
3. Technical support and community networks for providers

A. Training

Background

The education and training, including cultural and linguistic training, of child care teachers, family child care and exempt care providers is an indispensable part of child care quality. In California, formal early childhood training is provided primarily through the community college system, supplemented by workshops and courses provided by child care resource and referral agencies, professional organizations, conferences, in-service programs and other organizations. Training in languages other than English is in short supply, particularly in the formal community college training system. The Child Care Resource and
Referral Network has developed extensive training resources in Spanish
for family child care providers. A coordinated system of accessible, affordable, quality training programs and opportunities for professional growth for all types of child care providers should be available in each county in order to ensure and promote high-quality child care for children birth to five years of age.

Strategies for Consideration

- Assess the availability and quality of training opportunities for child care providers, as well as the opportunities for professional "career ladder growth".
- Develop or support training opportunities that address identified gaps.
- Determine which child care programs are ready and confident in their ability to identify children with special needs and/or developmental delays.

Planning Considerations

- Where and when is training provided? Are geographic locations, types of settings and hours of training appropriate for the audience served? Is training provided close to where providers are located? Is training free, or available at a
- reasonable cost?
- Are all courses or workshops that are required for licensure as a family child care provider, or for work as a center teacher or director, available in the county? How frequently are they provided?
- Is training linked with better compensation, professional certification standards, career ladder opportunities and retention?
- Is training available that is specifically tied to working with particular age groups, including infants and toddlers?
- Is training and support available to assist child care programs in caring for children with special needs?
- Are the Child Care Food Monitoring visits to child care facilities used to train providers in areas beyond nutrition, such as anemia, lead poisoning, dental care, asthma, identifying special needs, etc.?
- Is there training and support for informal, license-exempt providers?
- Do providers have access to training in basic skills (literacy, writing, etc.) as needed?

- Are there supports to programs that allow providers to attend available training (e.g., paid time off, provision of substitutes)?
- Do courses and workshops address diversity and cultural competence in child care programs?
- Is training offered in languages reflecting the population of providers, children and families in the county?
- Are various training model approaches employed?
- Are there financial and transportation barriers to accessing training?
- Is "cross training" available that links child care and child development with other family support services?
- Are local child care resource and referral service agencies aware of the programs for children and families with special needs that are sponsored by the Regional Centers?
- Are child development programs provided in the least restrictive environments, allowing children with disabilities and their families access to services?
- Are early childhood providers trained on brain research as it effects learning? Are these providers trained to work with children with disabilities and delays, including children with emotional and behavioral challenges?

B. Compensation and Retention of Providers

Background

The compensation for the child care workforce is at a level that is difficult to recruit and retain skilled teachers and providers. Research has found direct links between low compensation and high job turnover to diminished quality. In particular, high turnover creates a detrimental situation for young children who experience discontinuity and loss with each significant change of caregiver. Since high-quality child care is more costly to provide than what most parents can afford to pay, additional funds are needed to bridge the gap between parent fees and child care worker earnings.

Strategies for Consideration

- Collect information as needed on the compensation and retention of qualified child care teachers and providers in the county.
- Develop a program or fund to boost compensation and retention.
- Assure better continuity of care for children and families.

Planning Considerations

- Are data available on the average wages for child care assistants, teachers, directors and family child care providers, and on annual turnover rates, in the county? To what degree are trained caregivers in the county staying in the child care and early education field? For what length of time do positions typically go unfilled, or do programs hire personnel who do not fully meet qualifications?

- Are training efforts linked to better compensation (e.g., stipends) and career advancement opportunities for teachers and providers? This includes for example, the California Early Childhood Mentor Program, which trains experienced caregivers to mentor novice staff, in return for stipends and other professional opportunities.
- Has the County Commission considered establishing a local program to provide stipends and/or incentives tied to education and experience to improve wages? One model, now being implemented in San Francisco and under consideration in several other counties, would create a "Child Development Corps" of experienced caregivers. Members receive stipends based on their education and experience, in exchange for
- committing themselves to stay on the job for a certain period of time and to continue pursuing their professional growth.
- Are enhanced reimbursement rates offered for programs and providers who achieve accreditation or improve staff compensation and retention?
- Do home-based or private providers have sufficient access to opportunities to save on program-related costs, including access to the Child and Adult Care Food Program, and training in small-business management skills?
- Do child care providers in the county have access to affordable health insurance? Is there the potential for child care programs to purchase health care insurance as part of a larger purchasing group?
- Is there a central registry, pool or other mechanism for recruiting and dispatching qualified child care substitutes, or can one be developed?

C. Technical Support and Community Networks for Providers

Background

Providing high-quality child care services is a multi-faceted undertaking, requiring business and financial skills, knowledge of child development, awareness of health and safety issues, and the ability to work effectively with families and others in the community. Assistance with and support for the many aspects of running a child care program can help programs and providers start up, operate on a sound financial footing, provide quality child care to young children and stay in business longer. Opening and operating a child care program also requires compliance with local laws and regulations such as zoning, fire and building codes. Local requirements, such as restrictive zoning regulations, can become an impediment to developing child care programs in a community. Department of Social Services Community Care Licensing agencies are a resource for County Commissions considering these issues.

The quality and safety of the physical facilities of child care programs are of particular concern. Providing training and education on the removal of common environmental

hazards for children and adults, such as asbestos, lead paint and pesticides, should be a priority for all child care settings. Facilities should also be free of fire hazards and comply with all building and earthquake safety codes.

Finally, child care programs are of the highest quality when parents, child care providers and the community at large work together. The ongoing involvement of parents with their children's home- or center-based child care program is an indispensable aspect of quality, but involvement from and partnership with the greater community are also crucial. In particular, engaging local business, labor and faith communities, as well as agencies offering related support services for children and families, can greatly increase the base of public support for quality child care. Caregivers themselves, who are in contact with families on a daily basis, are an excellent source of information about the supports and services that families need.

Strategies for Consideration

- Research and evaluate the technical assistance resources currently available for child care providers, and develop efforts to fill gaps in services.
- Promote parent and community involvement with child care programs.
- Establish links between child care providers and other resources, including mental health services for children and families, to build the capacity of child care programs to serve as sites for integrated services, (e.g. parent education, family support, health and mental health consultation and early assessment).

Planning Considerations

- Are child care programs and providers served by organizations that provide start-up and ongoing assistance to small businesses, including business management, tax information and assistance, information on applicable laws and regulations, and
- facilities planning? County Commissions and communities may wish to promote partnerships with private-sector businesses and organizations that can offer business-skills training and technical assistance to child care providers.
- Do child care providers have appropriate access to credit and loans in the community?
- Do home-based providers have access to technical assistance consultation by telephone or home visit?
- Are child care providers, as well as other service providers, familiar with child care resource and referral services, child care subsidies, the Child and Adult Care Food Program and available choices of child care settings?
- Can home-based providers be reached directly where they work through such services as home visits, the Child and Adult Care

Food Program and mobile lending libraries for toys, equipment and books?

- Are programs available to educate and train providers on how to abate environmental hazards in child care homes or centers?
- Do all providers, including those who are exempt from licensing, have knowledge of how to create a safe child care environment?
- Do parks and other public outdoor facilities meet sufficient standards for safety?
- Are there efforts to educate child care consumers, and the community at large, about the importance of quality child care for school readiness and family stability, and the importance of a well-trained and well-compensated child care workforce?
- Is there support to help child care centers and family child care homes become accredited?

ADEQUATE AND ACCESSIBLE SUPPLY OF HIGH-QUALITY CHILD CARE

All parents want warm, attentive caregivers for their children, and environments that help their children grow and learn. But parents do not always have the information or financial resources that allow them to choose the child care program that best meets their family's needs. Additionally, the availability of high-quality child care, especially for infants and toddlers, is often in short supply.

Families must be able to locate and obtain child care that meets both children's needs and parents' schedules. For information about the supply of licensed care in their jurisdiction, County Commissions can contact local child care resource and referral agencies, local planning councils, county child care coordinators and district Community Care Licensing offices. Local child care payment agencies, including county human services departments, may be able to help determine the numbers of families receiving subsidies who are using care that is exempt from licensing (e.g., care provided by friends or relatives, or those caring for children from only one family). Often, however, hard data about the availability of relatives, friends and other license-exempt caregivers are not readily available.

In assessing supply, it is important to determine whether all parts of the county are being served, and to identify transportation and other barriers that prohibit families from accessing child care. It is also important to consider the work patterns and job participation rates of families with young children to better understand local child care needs. Other key components of access are whether the available supply matches families' needs in terms of ages of children served, special needs of children, hours of operation, geographic accessibility of child care centers, costs and linguistic needs of families in the county.

Commissions may consider creative measures to support the increased availability of child care programs for infants and toddlers, children with special needs, families requiring care during non-traditional hours, and children of specific linguistic and cultural

populations – and to retain a stable and well-trained caregiving workforce in order to keep these programs available. In some communities, licensable facilities may also be in short supply. In others, assistance may be needed to help programs comply with environmental issues, Americans with Disabilities Act (ADA) requirements and other regulations.

While all families with young children struggle to find high-quality programs that they can afford, families of children with special needs face particularly steep hurdles. But inclusion in a high-quality child care program can be a crucially positive influence for a child's ability to integrate meaningfully into his or her community and to socialize with non-disabled peers. Child care priorities for children with disabilities and their families should be based on current and accurate data. It is also important for multiple agencies, including child care programs, early intervention and family support services, Regional Centers, resource and referral agencies, school districts, and health providers, to work together in a coordinated way to assist children with special needs.

Goal

Promote the accessibility of high-quality child care and early education services to all families who need them.

Strategies for Consideration

- Evaluate the county's present child care supply in order to address gaps in services.
- Develop efforts to assist programs in start-up, licensing, accreditation, renovation, and facilities improvements.
- Encourage the development of facilities in under-served neighborhoods and near centers of employment.
- Encourage utilization or expansion of child care program space in faith-based organizations.

Planning Considerations

- Are providers themselves aware of unmet child care needs in the county, including under-served populations and age groups such as infants and toddlers, certain linguistic and cultural groups, and children with special needs? Can targeted outreach and recruitment efforts to local providers help fill such service gaps? Is funding available for such outreach and recruitment efforts?
- Are programs available, or can they be established, to provide low-cost loans for purchasing child care facilities, for remodeling child care homes or centers, or for upgrading facilities to comply with health and safety regulations?
- Is assistance available to help facilities remove lead or other toxic materials, provide safe water, meet fire codes and ADA requirements, etc.?
- Do local public transportation routes help or hinder families in commuting between home, child care programs and work?

- Are families educated about all available child care options in the community? Do parents know where to go for information? Are they told about the benefits of choosing a provider who participates in the Child Care Food Program?
- Is the information about all aspects of child care, including referrals and licensing, subsidy and food program information, available in languages other than English?
- Are Child Care Food Programs being used to help new providers become licensed?
- Are child care facilities encouraged in ethnic/cultural neighborhoods or near development centers?
- Are resource and referral agency personnel informed about special needs issues, including the roles and responsibilities of Regional Centers and school districts in providing support services for children and families?
- Is the faith community involved in assessing and increasing the supply of child care?

AFFORDABLE CHILD CARE FOR ALL FAMILIES

Many families cannot afford to pay the full cost of quality child care services, and it is of considerable (and rising) concern that they cannot be the sole funding source of measures to increase the stability of child care teachers and providers. In 1996, for example, the average cost of full-time care for a child under age two in a licensed child care center was $135.00 per week, $7,020 per year, or 59 percent of an annual minimum wage salary. For children ages two to five, the average cost of full-time care in a licensed center was $94.00 per week, $4,888 per year, or 41 percent of an annual minimum wage salary. According to the California Employment Development Department and the U.S. Bureau of Labor Statistics, four out of five of the fastest-growing occupations in California between 1993 and 2005 are expected to pay below $6.00 per hour. At this salary level, a full-time wage earner with two children will not earn enough to live above the poverty level, or to pay for child care without substantial financial assistance.

Many families need financial assistance in securing and using the high-quality child care services that best meet their needs. There are a variety of subsidies available, but due to limited funding, restrictions in eligibility criteria and sometimes to lack of outreach, they reach only a fraction of eligible families. Individual providers and center-based programs may also need assistance to ensure their financial viability; without assistance from sources other than parent fees, child care programs are often unable to provide decent compensation for staff, which leads to high turnover, lower quality and less accessibility for families.

Goal

Assure affordable child care services to all families in the county who need them, as well as adequate resources so that child care programs and providers can provide high-quality, reliable care.

Strategies for Consideration

- Work with employers in communities to provide high-quality, onsite child care programs.
- Develop outreach to providers to ensure their awareness and utilization of sources of public and private support.
- Expand outreach to parents to ensure they are knowledgeable about programs and services that assist families in meeting the cost of child care.

Planning Considerations

- Do families have adequate information in order to understand all available sources of financial support, including child care subsidies and tax benefits?
- Do providers have adequate information about all sources of public and private financial support, including subsidy programs, payment systems, tax credits and nutrition assistance through the Child and Adult Food Program?
- Is it possible for eligibility applications for various types of financial support to be standardized?
- Are eligibility lists for financial support centralized? Are they accurate for data assessment efforts? Are they managed efficiently in order to be timely, effective and helpful for families?
- Can County Commission allocations or other local funds be devoted to increasing available subsidies for families and providers?
- Can local employers be more actively encouraged to assist employees with child care expenses as part of their benefit plans?

REFERENCES

A. Mitchell, L. Stoney & H. Dichter. *Financing Child Care in the United States: An Illustrative Catalog of Current Strategies.* Kansas City, Mo.: Ewing Marion Kauffman Foundation, and Philadelphia, PA.: Pew Charitable Trust, 1997.

Bay Area Network of Diversity Training and Education in Child Care (BANDTEC).

California Child Care Resource and Referral Network, San Francisco.

California Child Care Training Consortium, California Department of Education.

California Interagency Coordinating Council on Early Intervention.

Center for the Child Care Workforce (CCW): child care salary and benefits data available for a number of California counties, as well as technical assistance on workforce compensation and retention issues. See also 1997 publication, *Making Work Pay in the Child Care Industry: Promising Practices for Improving Compensation*, and

CCW's annual compendium of *Current Data on Child Care Salaries and Benefits in the United States.*

Center for the Future of Children, David and Lucile Packard Foundation, 1996 publication, *Financing Child Care*.

Child and Adult Care Food Program (offering financial assistance, and nutrition and other training, for eligible providers).

Child care professional associations, including state and local family child care associations, and the California Association for the Education of Young Children.

Community Care Licensing Offices.

Community Colleges.

H. Chang, A. Muckelroy & D. Pulido-Tobiassen, *Looking In, Looking Out: Redefining Child Care and Early Education in a Diverse Society.* San Francisco: California Tomorrow, 1996.

Local Child Care Planning and Advisory Councils.

Local Child Care Resource and Referral Agencies.

Regional Centers.

California Early Childhood Mentor Programs.

FOCUS AREA THREE: HEALTH AND WELLNESS

STRATEGIC RESULT – IMPROVED CHILD HEALTH: HEALTHY CHILDREN

Health and wellness focuses on integrated services and systems to optimize individual, family and community health. Ideally, health and wellness activities should be dedicated to creative efforts that support families and enrich the development opportunities for all children prenatal to five, so they reach their maximum potential.

The State Commission recognizes that health and wellness is more than the absence of disease. A broad health and wellness definition includes the following components:

- Multiple determinants including physical, spiritual, emotional, environmental and intellectual factors impact health.
- Health and wellness are affected by interrelated factors along a continuum that includes individual, family and community.

- Strategies that impact health may include interventions at multiple levels to protect, promote and preserve optimal health.

In this section of the Guidelines, a variety of health and wellness topic areas are briefly discussed. While the topic areas are presented in a categorical manner, it is important to consider them in relationship to one another. Many of the objectives for consideration that have been offered in a single area relate to objectives in other areas. Moreover, the objectives should be considered within the broader context of the Guidelines' other Focus Areas – Child Care and Early Education and Parent Education and Support Services – with which there is also likely to be considerable relationship.

In developing the following topic areas, many of the objectives for consideration which are presented have been drawn from the Draft Healthy People 2010 Objectives, which were developed by the U.S. Department of Health and Human Services and are being finalized for release in January 2000. These objectives are included to stimulate consideration and discussion and assist County Commissions in their identification of objectives for consideration consistent with the needs and conditions of their communities. They are not intended to provide an exclusive list of objectives for consideration for County Commissions.

In some areas where an objective was more broadly presented in the Draft Healthy People 2010 publication, it has been tailored here to meet the needs of pregnant women or young children from birth to age five, consistent with the provisions of the California Children and Families Act.

ACCESS TO QUALITY HEALTH SERVICES

Background

Approximately one in five children in California are uninsured and approximately one in four have no regular health care provider. Moreover, there are striking differences in health insurance across racial and ethnic groups in California. Notably, 29 percent of Latino children are uninsured, the largest percentage in the state. Many disparities in the health status of different population groups are associated with problems of access to preventive and primary care services.

What do the lack of health coverage and the lack of a regular health care provider mean for young children? They mean the child is less likely to receive appropriate immunizations and regular preventive care, and that treatment for illness or injury may be delayed until they become serious health problems. They mean there is no consistent medical provider involved in the child's care. They mean there is no "medical home" where the child's physical and mental development are regularly assessed to make sure appropriate developmental milestones are being met. They mean early opportunities to identify vision, hearing or other problems can be missed – problems which can undermine a child's later school readiness. Access to quality health services during a child's early years is crucial for healthy development.

In California, children receive health care services through a variety of coverage arrangements. These include employer-sponsored health insurance, health insurance purchased in the private market, Medi-Cal, the Healthy Families Program, the Child Health and Disability Prevention (CHDP) program and the Access for Infants and

Mothers (AIM) program. These alternative types of coverage provide differing levels of benefits and differing arrangements for the delivery of care, both of which have an impact on the extent to which a child's health care needs are addressed.
A wide body of research shows that children without health coverage do not receive needed health care services and are less likely than insured children to receive primary and preventive care services, such as check-ups and appropriate immunizations. Importantly, and at the same time, similar research shows that even when children are insured, many have problems obtaining necessary care due to access barriers. Barriers can include the lack of insurance; lack of nearby facilities; lack of provider training in prevention; cultural, language and knowledge barriers; and physical barriers. In California, the diversity of our population makes assuring cultural and linguistic competency on the part of health care providers and health care systems particularly important. This competency includes assuring that services are available to children and families in their communities. A lack of this competency imposes an added barrier of access for ethnic minority children and families.

Objectives for Consideration

- Reduce the proportion of children aged zero to five without health insurance coverage.
- Increase the proportion of children under age five who have a specific source of ongoing primary care.
- Reduce the proportion of families with children aged zero to five who report they did not obtain all the health care that they needed.
- Reduce preventable hospitalizations for chronic illness among young children, such as pediatric asthma and immunization-preventable pneumonia and influenza.
- Increase the proportion of providers with formal cultural competency training.

Strategies and/or Planning Considerations

- Expand health insurance coverage.
- Strengthen community-based efforts to promote the utilization of health services.
- Assure all children eligible for Medi-Cal, Healthy Families and other state programs are enrolled.
- Assure pregnant women are enrolled in Medi-Cal, AIM and other programs.
- Develop creative and innovative methods to distribute health services information to parents, including technology links to community-based organizations and increased utilization of Community Health Outreach Workers (CHOWs).
- Use CHOWs to link parents and children with community services.
- Encourage guidance from physicians and other health services providers to parents about child development, adopting healthy behaviors, using medications appropriately, getting immunizations and check-ups, addressing behavioral or discipline issues and making appropriate use of medical services.
- Establish nurse-staffed telephone assistance services.

- Promote community-based strategies outside of the traditional health care system that link preschools, schools, parents and community-based health care programs to assure early identification of illness and risk for injury, and provide referrals for child care and safe recreation alternatives.
- Promote a strong public health system with linkages to the community and the medical provider community.
- Monitor and report on changes in the health status of young children at the county level to guide future planning.
- Annually measure and report on the performance of health plans and medical providers in delivering preventive services to children and families.
- Identify and report on barriers to the delivery of preventive services and how they are overcome.

MATERNAL, INFANT AND CHILD HEALTH

Background

Prenatal care includes risk assessment, risk reduction and education. Each of these components can contribute to reductions in prenatal morbidity and mortality by identifying and mitigating potential risks and helping women address the behavioral factors, such as smoking and alcohol use, which contribute to poor health outcomes for themselves and their children. The use of timely, high-quality prenatal care has been shown to help prevent poor birth outcomes.

Part of this care should address the prevention of developmental disabilities, the most common group of disorders that cause lifelong disability. Although many disabilities may not be recognized until the child is challenged in school, the majority of developmental disabilities are caused by events occurring in the prenatal and infant periods. Thus interventions to decrease the prevalence of underlying disabling conditions must be targeted to prevent known causes before they occur. This would include targeting risk behaviors that include using tobacco products, illicit drug use and alcohol use, as well as enhancing protective behaviors that benefit the fetus such as nutrition and prenatal care.

Several risk factors are specifically related to poor birth outcomes, including infant mortality, but foremost among these are low birth-weight (LBW) and pre-term delivery. LBW and short gestation are the risk factors most closely associated with poor birth outcomes that include long-term disabilities such as cerebral palsy, autism, mental retardation, vision and hearing impairments and other developmental disabilities. Implementing strategies that protect infant birth-weight as well as addressing maternal behavior can contribute substantially to reducing adverse health outcomes for newborns.

Objectives for Consideration

- Reduce the infant mortality rate.
- Reduce the incidence of child mortality for children aged one to four years.
- Reduce the incidence of LBW births.

- Increase the percentage of women who breastfeed their infants (in early postpartum, until six months old, until one year old).
- Increase the proportion of all women who receive prenatal care in the first trimester.
- Increase the proportion of women who receive a postpartum visit four to six weeks after delivery.
- Increase the proportion of providers of primary care to women of reproductive age who routinely provide preconception counseling about risks to a healthy pregnancy.
- Increase the proportion of pregnant women who attend a formal series of prepared childbirth classes.
- Increase proportion of babies aged 18 months and younger who receive recommended primary care services at appropriate intervals.
- Increase proportion of health providers who refer or screen infants and children for impairments of vision, hearing, speech and language and assess other developmental milestones.
- Decrease the proportion of pregnant women who smoke or live in households with smokers.

Strategies and/or Planning Considerations

- Provide cultural competency training for health providers.
- Develop culturally competent maternal, infant and child health education materials for parents.
- Establish public health nurse home visit program following delivery of newborns.
- Provide health provider training to identify at-risk mothers (underweight, overweight, substance abuse).
- Educate pregnant women about harmful effects of alcohol, tobacco and other drugs.
- Educate pregnant women about the importance of nutrition, prenatal vitamins, folic acid and breastfeeding.
- Establish education programs to change the skills and attitudes of future parents.
- Involve all medical personnel (physicians, nurses, etc.) and social services agencies in educating parents about maternal, infant and child health.
- Increase access to the Women, Infants and Children (WIC) program.
- Partner WIC agencies with private health organizations.
- Establish and expand Family Resource Centers to serve a broad range of needs of women and children.
- Establish outreach programs, including mentoring and support groups, for at-risk mothers.
- Develop reminder/recall systems for postpartum checkups, regular pediatrician visits and immunizations.
- Promote public awareness campaigns involving employers, civic and community leaders and the faith community, among others.

- Provide kits for new parents with educational materials and information on support resources, child care, etc.
- Increase links between the public health and the private medical system with the State Regional Centers to provide assessments, treatment and follow-up services.

CHILDREN AND FAMILIES WITH SPECIAL CONDITIONS

Background

Children with special conditions and disabilities account for approximately 20 percent of the population of all children.

According to the Centers for Disease Control and Prevention (CDC), approximately 17 percent of school age children have a developmental disability. According to the CDC, "Developmental disabilities are a heterogeneous group of physical, cognitive, psychological, sensory, and speech impairments that arise during development from birth to 18 years of age."

Research demonstrates that early intervention and education programs for children with disabilities and developmental delays enhances development, provides important family support and reduces the need for future services.

While some children with developmental disabilities are easily identified at birth, other disabilities are not identified until the child is much older. According to the National Institute of Health, most children with learning disabilities are not identified until the third grade, long after they have experienced school failure. For this reason, it is critical to identify children with developmental delays or risk for developmental delays as early as possible.

Young children with disabilities, developmental delays and risk for developmental delays receive services from a number of agencies, increasing the need for integrated and comprehensive planning in this area. Frequently there are gaps in eligibility and service delivery during the early childhood years. As a result, due to the complexity of multiple agency roles and challenges, many children who would benefit from timely assessment and intervention may not be attended to. Additionally, children with disabilities often face substantial barriers in accessing health and child care services available to non-disabled children.

Objectives for Consideration

- Increase the number of children with disabilities who have access to comprehensive early intervention services.
- Increase the number of health care providers trained to identify and serve children with disabilities and delays, including children with early emotional, behavioral and learning challenges.
- Increase communication efforts to promote utilization of health services for timely assessment and treatment of children with disabilities or delays.
- Reduce the number of young children residing in institutions.

- Expand long-term services and supports to allow families to care for their children at home, rather than in institutions.

Strategies and/or Planning Considerations

- Assess the quality and scope of existing early intervention services in meeting the needs of children with disabilities, children with developmental delays and children at substantial risk of developmental delays, to expand services to children in
- need.
- Improve early screening and identification of children with disabilities, developmental delays and substantial risks for developmental delays.
- Improve access to early intervention services for children with a full range of disabilities and delays.
- Expand early intervention services to children with increased risk for developmental delays, including children with teen parents, children with parents who have mental health impairments or developmental disabilities, and children of parents who have substance abuse problems.
- Ensure continuation of comprehensive developmental services for children with a range of disabilities, delays or risk for delays, beyond the zero to two age period, when services for these children are frequently reduced.

CHILDREN AND FAMILIES AT RISK: DEVELOPMENTAL DELAYS

Background

One of the most significant and cost-effective outcomes of early childhood development results from providing assistance to children who are at risk of a developmental disability or who may require special education support services later in their lives. When developmental delays and other risk factors are recognized early and addressed with appropriate and culturally sensitive programs and services for the child and family, these delays often disappear before kindergarten, rather than developing into long-term problems.

Every year in California, our public schools provide special education services to nearly 500,000 children K-12, with speech and language impairments and with specific learning disabilities. In each grade level there are approximately 40,000 children with speech, language or learning disabilities. When children are identified in the early years, and when their families receive early intervention services, the needs for special education during school years diminish.

Identification of children with high risk factors for school failure may occur through different providers. These sites may include regular well-child visits with primary care providers, Child Health and Disability Prevention (CHDP) screenings, nursery school and kinder-gym programs, preschool and other early education child care settings, and Women, Infant and Child (WIC) programs. In some cases, children at risk may be identified at birth, when hospitals, clinics, and physicians have time and resources, as well as places for referral, particularly when these assessments identify risk factors such

as limited prenatal care, maternal drug and alcohol use, family poverty and maternal age under 19 years.

Objectives for Consideration

- Increase the county's capacity for public health follow-up of infants born at risk of a disability or significant developmental delay.
- Increase the number of infants referred for and receiving public health follow-up who may be at risk of a developmental delay.
- Increase the number of early education personnel qualified to administer and analyze developmental assessments of young children.
- Reduce the percentage of children in kindergarten and first grade who are referred for special education services.
- Increase the level of early intervention services, such as speech and language development, provided by specialists and trained child care providers in outpatient settings, preschool settings and child care settings.

Strategies and/or Planning Considerations

- Improve linkages, communication and referrals between families with children who have special needs and public health, county offices of education, private providers, community clinics, CHDP, HMOs, WIC Programs, hospitals, child care and early education programs.
- Within each county, identify the range of services, including genetic counseling, available to children with developmental delays and their families. Address any local gaps in services.
- Determine if genetic counseling services are available to all parents, and assess the availability and affordability of prenatal care.
- Increase health insurance coverage for young children.

ENVIRONMENTAL HEALTH

Background

Research shows that human exposure to hazardous agents in the water, air, food and soil is a major contributor to increased disability, morbidity and mortality. Children are particularly susceptible to environmental hazards. These include the effects of various chemical, physical and biological agents, as well as the effects of the broad physical and social environment, including housing, urban development, transportation and industry.

For young children, a particular source of environmental hazards is the home environment and other care settings, such as the home of a day care provider, a

preschool or elementary school. Many children are exposed to tobacco smoke at home, which places them at an increased risk of asthma and lower respiratory tract infections. Hazardous household chemicals are another environmental risk at a child's home or day care setting. Potential poisoning sources can be found around any house and include cosmetics, cleaning substances, over-the-counter medications and plants.

In addition, lead poisoning is a particular concern for young children. The developing brains of fetuses and young children are particularly vulnerable to elevated blood lead levels, which can adversely affect a child's intelligence, behavior and development, and potentially damage the nervous and reproductive systems. Nationally, there are an estimated 1.7 million children aged one to five with elevated blood lead levels (BLLs). The prevalence of elevated BLLs is higher among children who are African American, Mexican American, are part of lower-income families and are living in large metropolitan areas or older housing.

Pregnant women are at risk of exposure to pesticides. Pesticides pose a significant health risk to the fetus, including developmental and physical abnormalities. Many farm workers without child care bring their families to the fields, placing their newborns, infants and children at risk of exposure to pesticides. Exposure to pesticides has been found to lead to learning disabilities and immunity problems in children. In addition, many families in rural areas live within proximity to agriculture fields that are sprayed with pesticides, but are unaware of the danger that pesticides place on their unborn fetus and/or their children.

Objectives for Consideration

- Reduce the level of blood lead levels exceeding 10 ug/dL to 0 in children aged one to five.
- Reduce the proportion of children aged five and younger who are regularly exposed to tobacco smoke at home.
- Increase the number of homes built before 1950 in which testing for lead based paint has been performed as a means to reduce childhood lead poisoning.
- Reduce deaths and nonfatal poisonings of children under age six from exposures to household hazardous chemicals.
- Reduce the number of pregnant women exposed to pesticides.
- Reduce the number of children under age five exposed to pesticides.

Strategies and/or Planning Considerations

- Increase parental education and awareness about environmental hazards to child health.
- Increase training and education of physicians and other health care providers, especially to threats existing in the communities they serve.

- Provide lead screenings for at-risk young children in preschool and day care settings.
- Provide communities with mobile lead-screenings in public settings (health and safety fairs, malls, libraries, preschools, day care centers, etc.).
- Provide education to farm workers on the danger of pesticides and their potential impact on the fetus and children.
- Provide information to renters and homebuyers on how to identify potential hazardous threats.
- Conduct community-based home environment safety fairs.
- Screen parents and children during health care visits to determine exposure to secondhand smoke in the home.
- Assess care settings for levels of environmental risk and educate providers about strategies available to them to abate these risks.

CHILDHOOD IMMUNIZATIONS

Background

Infectious diseases continue to remain major sources for morbidity and mortality in the United States. In the case of newborns, the immunity from many diseases that they acquire while in the womb usually wears off in the first year of life. Vaccination is important at these early stages of life to safeguard the newborn from illness and death caused by infectious diseases. Vaccines play a powerful role in preventing the debilitating and sometimes fatal effects of infectious diseases such as measles, mumps, polio, rubella, pertussis, chicken pox and hepatitis B.

Following the recommended immunization schedule for newborn to preschool-age children is important because these children have not built up strong immune systems and are especially susceptible to disease. Experts agree that all children age zero to two years should be immunized against all preventable childhood diseases. Although up to 98 percent of children in the United States are vaccinated before or shortly after starting school, the proportion of preschool children who have completed a full series for all recommended vaccines is considerably lower. In many communities, more than 50 percent of two-year-olds had not been fully immunized, leaving them vulnerable to diseases like pertussis, polio, diphteria, mumps and tetanus. The resurgence of measles in the United States during the period 1989-1991 was associated with 55,622 reported cases, 11,251 hospitalizations and 166 suspected deaths from measles. The cause of the epidemic was the failure to vaccinate according to the recommended schedule.

Additionally, providing immunizations for mothers-to-be is critical to protect the fetus from possible illnesses that the mother may be exposed to and could create dire consequences for the newborn. In the 1960s, more than 20,000 infants were born with major malformations including deafness, blindness, congenital heart disease and mental retardation due to rubella virus infecting their pregnant mothers. The protective value of immunizations is evident when immunization levels in a community are high.

Those who are not vaccinated are indirectly protected because they are surrounded by vaccinated persons and do not get exposed to disease.

Objectives for Consideration

- Reduce indigenous cases of vaccine-preventable diseases for children aged zero to five.
- Reduce chronic Hepatitis B infections in infants.
- Increase efforts to address Hepatitis B infections in all adults, with particular focus on sub-populations with high infection rates.
- Achieve full immunization coverage for children 19-35 months of age.
- Maintain immunization coverage for children in licensed day care programs and children kindergarten through first grade.
- Strengthen outreach and education efforts to address significant racial disparities in immunization rates.
- Increase the proportion of two-year-olds who are on-time for immunizations as part of comprehensive primary care.

Strategies and/or Planning Considerations

- Develop and establish immunization tracking/reminder/recall systems in both private practices and public clinics.
- Link immunization programs with other programs, such as WIC's Special Supplemental Food Program, AFDC and Head Start.
- Provide onsite immunizations at schools and child care centers according to standards set by state and county health departments.
- Educate child care providers and parents about vaccines (types, importance, schedule, adverse reactions, etc.).
- Involve all medical personnel (physicians, nurses, etc.) in screening children and educating parents about immunizations.
- Develop and establish programs that provide free vaccines to uninsured children, especially through home visits.
- Improve data assessments to better distinguish sub-population rates for on-time immunization.
- Encourage employers to offer insurance that covers vaccines and allow parents time off to immunize their children.
- Establish worksite immunization program.
- Develop state- or county-wide registries to track immunization status and notify parents when immunizations are required.
- Improve communication and registry links between clinic, public and private providers.

- Establish partnerships and coalitions among public and private groups at the local, state and national levels to promote immunization.

NUTRITION

Background

Good nutrition is important for sustenance, growth and development, health and well-being throughout life. It is particularly essential for pregnant women and growing children aged zero to five to have a nutritious diet to allow the child's brain, other organs and bones to reach their full potential. Although it is known that nutrition and diet behaviors affect health, food insecurity (hunger) is an important factor that contributes to nutritional status. Households that have children, and single women, minorities and incomes below the poverty line appear to have a much greater risk of hunger. In a 1995 report by the Census Bureau, nearly one in five, lived in households that either did not get enough to eat or did not get the kind of foods that they wanted to eat, and that approximately 6 percent of all U.S. households with children suffer severe or moderate hunger (4.2 million children). It is critical for mothers-to-be to have good nutritional eating habits to ensure the best possible prenatal conditions for their child. Moreover, it' important for parents to establish healthful diet behaviors early in the child's life to assure the child will grow and develop to his or her fullest potential.

Many dietary components are involved in nutrition and health relationships. Chief among nutritional problems is the disproportionate consumption of foods high in fat, often at the expense of foods high in complex carbohydrates, fiber and other substances conducive to good health that are found in fruits, vegetables and grain products. Oftentimes in young children, nutritional inadequacies such as these can affect growth and long-term health.

Overweight and obesity acquired during childhood or adolescence may persist into adulthood and increase the risk for some chronic diseases later in life. Overweight is not limited to adults, but may be observed in children. These conditions in young children not only have negative health implications later in life, but often result in increased psychological stress that could precipitate other negative health outcomes.

Objectives for Consideration

- Reduce growth retardation for low-income children aged five and younger.
- Reduce iron deficiency for young children and women of childbearing age.
- Reduce the prevalence of overweight and obesity in children aged zero to five.
- Reduce the incidence of anemia in pregnant women in their third trimester.
- Increase the proportion of young children and pregnant women who meet the minimum average daily goal of at least five servings of fruits and vegetables.
- Increase the proportion of young children and pregnant women who meet the minimum average daily goal of at least six servings of grain products.
- Increase the proportion of young children and women who meet the average daily goal of no more than 30 percent of calories from fat.

Strategies and/or Planning Considerations

- Provide health providers with education about nutrition and effective strategies to get people to improve their diets.
- Make nutrition counseling a part of primary care visits for young children.
- Promote nutrition counseling for pregnant women.
- Train health providers to identify at-risk mothers (i.e., those who are underweight at conception).
- Promote nutrition education through Medi-Cal managed care organizations.
- Promote access to the Women, Infants and Children (WIC) program.
- Partner WIC agencies with private health organizations to address nutritional needs of pregnant women and children.
- Assist low-income families in obtaining fresh fruits and vegetables.
- Expand availability of community gardens.
- Provide training in food preparation to families with young children.
- Promote educational and peer support programs for new mothers about the importance of breastfeeding.
- Encourage employers to provide workplace areas set aside for breastfeeding/pumping.
- Promote community campaigns about good nutrition (e.g., “Five a
- Expand availability of iron-fortified formulas (when formulas are used).
- Create simplified literature/educational materials about nutrition for use by parents.
- Expand breakfast and lunch programs at day care centers and preschools.

PHYSICAL ACTIVITY AND FITNESS

Background

Children and adults benefit from a lifestyle that includes regular, vigorous physical activity. Regular physical activity has long been known to reduce the chance of heart disease, the number one cause of death in the United States. Research shows that active people outlive those who are inactive.

While children are generally more active than adults, physical activity in children tends to diminish with age. For this reason, it is important for children and families to adopt and maintain a physically active lifestyle as early as possible. Research shows that even among children three to four years old, those who are less active tend to remain

less active than most of their peers after age three. Moreover, low-income and minority children are less likely to participate in sports activities. Physically active parents can serve as role models for children to maintain active lifestyles at any age.

Primary care providers play an important role in encouraging and supporting parents and children to adopt a physically active lifestyle. Most studies suggest that physical activity counseling in a primary care setting is successful in increasing physical activity, at least in the short-term. Moreover, pregnancy may be a particularly good time to encourage physical activity. New mothers, concerned about the health of their developing child, may be more willing to start a moderate exercise program, while already active mothers can be reassured that continued exercise will not harm a fetus. Healthcare providers can counsel pregnant patients that exercise during pregnancy is an important way to prepare the body for the physical rigors of childbirth and encourage women to maintain an active lifestyle during pregnancy that continues after the birth of their children.

However, outdoor activity should be enjoyed in a sun-safe manner that includes the use of sunscreen, protective clothing (weather permitting) and wide-trimmed hats.

Objectives for Consideration

- Increase the proportion of primary and allied health care providers who routinely assess and counsel pregnant patients regarding their physical activity practices.
- Increase utilization of public and open space areas by improving facilities and play structures in rural areas and in locations with traditionally under-served populations.
- Increase the number of public playgrounds that are accessible to children with disabilities.
- Increase the number of recreation programs available to children with disabilities.

Strategies and/or Planning Considerations

- Include screening for exercise/physical activity levels as part of standard maternal/pediatric medical exams.
- Offer free or low-cost prenatal and postnatal fitness programs through local parks and recreation departments.
- Increase public education efforts to communicate the benefits of good health and the risks of obesity, for both children and adults.
- Offer prenatal fitness programs in conjunction with WIC and other social services.
- Ensure that facilities and landscapes serving young children (e.g., schools, child care centers, libraries, playgrounds) are accessible to children with disabilities.

- Offer discounted or low-cost prenatal fitness programs at local health clubs.
- Encourage parents and caregivers to support children in practicing sun safety when they exercise outdoors.

ORAL HEALTH

Background

Dental caries, commonly known as tooth decay or cavities, is the most common disease among American children. Research shows that by the time children are just eight years old, more than half have had at least one cavity. However, oral diseases, including dental caries, can easily be prevented with early intervention and access to care.

Preventive dental services need to begin early in a child's life, since oral diseases can start at as young an age as six months, when the first tooth comes in, and feeding practices, such as putting a baby to bed with a bottle containing anything other than water, can seriously jeopardize a child's oral health. In 1997, among California preschool children, 31 percent had at least one tooth that was decayed or filled, and 27 percent had untreated decay.

According to the National Health Interview Survey (1995), over one-third of U.S. children have no dental coverage. In addition, cost is one of the principal barriers to needed dental care for families that have no dental insurance or for whom coverage is extremely limited. Children who are most likely to lack access to dental care include low-income children, members of ethnic or racial minority groups and children of parents with little education. These children are those most at risk for oral diseases in early childhood and into adolescence and adulthood. According to the same 1995 survey, 80 percent of all dental decay can be attributed to just 25 percent of all children.

Fluoridated water has led to important reductions in the prevalence of dental caries among children. However, the vast majority of California's population still receives non-fluoridated drinking water. A report by the Dental Health Foundation found that preschoolers in non-fluoridated urban and rural areas have higher rates of decay. In the absence of fluoridated water, other fluoride treatments, including professionally applied topical fluoride, fluoride dentifrice an fluoride mouth rinses have all been proven to prevent initial tooth decay and promote the repair of early-stage caries.

Objectives for Consideration

- Reduce the proportion of children aged zero to five with dental caries in their primary teeth.
- Reduce untreated caries in the primary and permanent teeth of children aged zero to five.
- Increase the proportion of two-year-olds who receive caries screening by a qualified health professional for the existence of any observable decay and counseling about fluoride and brushing.
- Increase use of topical fluorides for children aged zero to five not receiving fluoridated water.

- Reduce barriers that children with special needs face in accessing dental services.

Strategies and/or Planning Considerations

- Educate/train families, pediatricians and oral health providers about oral health and nutrition.
- Promote referrals to oral health providers by primary care providers.
- Assess community dental needs and expand community dental care facilities.
- Support community awareness about the benefits of fluoridated water.
- Expand the availability of preschool and community-based preventive dental programs, including fluoride varnish programs for high risk children aged zero to five and antimicrobial mouth rinse programs for mothers of young children.
- Utilize mobile trailers and equipment to deliver dental treatment to under-served populations (low-income areas, rural areas, homebound individuals, etc.).
- Encourage employers to expand dental insurance.
- Link oral health programs to WIC, Healthy Start and Head Start programs.
- Conduct community campaigns about oral health.
- Establish databases and patient registries for tracking history of dental care.

ALCOHOL AND OTHER DRUG USE

Background

Many Californians choose not to drink alcohol or limit their alcohol intake. Yet many others consume alcohol in quantities and frequencies that put them and others at risk of serious health or social consequences, including alcohol-related disease, unintentional injury and crime. Pregnancy and early childhood are critical developmental periods, during which fetal exposure to harmful substances can have consequences for life-long health. It is widely understood and recommended that pregnant women need to abstain from alcohol, including beer, wine, wine coolers and hard liquor, throughout their pregnancy and while nursing their babies. Pregnant women who consume any amount of alcohol put their developing fetus and baby at risk of miscarriage, low birth-weight, stillbirth, death in early infancy, intellectual impairment, developmental problems and fetal alcohol syndrome (FAS).

Fetal alcohol syndrome (FAS) is one of the most commonly known causes of mental retardation that is entirely preventable. It is a condition that inhibits fetal and infant development and often produces LBW babies, as well as physical and mental birth

defects. Even when FAS does not result in mental retardation, it can result in varying degrees of psychological and behavioral problems for children over their lifetimes.

The long-term consequences to development of a child born with drug exposure are serious. It is widely understood that pregnant women who use illicit drugs subject their unborn children to the same risks as those associated with alcohol use, and others, such as HIV/AIDS transmission and similarly transmitted diseases that are associated with injection drug use. Research shows children who have been exposed to drugs during pregnancy tend to be medically fragile, having been born with low birth-weight or prematurely, and may suffer a similar constellation of illnesses as that associated with exposure to alcohol. Pregnant women who used illicit drugs (such as heroin, methadone, PCP, crack, cocaine) may give birth to addicted babies who will undergo withdrawal. Moreover, substance abuse is rarely an isolated event and continued use/addiction may negatively affect the safety of a child's growing environment after birth.

For healthy development of their children, it is essential that mothers-to-be address the needs of their developing babies in an environment, whether in the womb or at home, that is not compromised by harmful substances.

Objectives for Consideration

- Increase abstinence from alcohol use by pregnant women.
- Eliminate use of illicit drugs by pregnant women.
- Reduce incidence of fetal alcohol syndrome (FAS).

Strategies and/or Planning Considerations

- Provide parent education about the effects of alcohol and other drug (AOD) use on pregnant women and children.
- Develop comprehensive health education that includes an AOD component.
- Train and educate social services/caseworker to identify pregnant women and family members at risk of alcohol or drug use and make appropriate referrals.
- Increase screening for AOD use through health providers and social service agencies.
- Increase access to treatment programs that are tailored to pregnant women and parents with small children.
- Provide training for foster parents providing care to children who are affected by AOD.

TOBACCO USE

Background

Tobacco use is the single leading preventable cause of premature death and disability in the United States – an acknowledged risk factor for heart disease; cancers of the lung, larynx, mouth, esophagus and bladder; and chronic lung disease. The health effects on the fetus are profound if a mother smokes or is exposed to secondhand or environmental tobacco smoke (ETS) during pregnancy. Research has shown that when a pregnant woman smokes or is exposed to tobacco smoke, the supply of oxygen and nutrients circulated to the fetus is adversely affected and has an injurious effect on the baby's development and survival.

Smoking cessation at all ages reduces the risk of morbidity and mortality. Cessation from tobacco use is of particular concern for pregnant mothers and is required to prevent the significant adverse effects of smoking on the health, wellbeing and development of the fetus and the newborn child. Smoking during pregnancy has been positively associated with pregnancy complications, stillbirth, and low birth-weight which has been shown to increase the risk of disease and death (Sudden Infant Death Syndrome) during infancy and early childhood, as well as have growth and health implications later in life.

Exposure of young children to secondhand or ETS has a devastating effect. It has been shown that children in households with parent(s) who smoke are more susceptible than children in non-smoking households to suffer from respiratory illnesses and infections such as bronchitis and pneumonia, reduced lung function, chronic middle ear infections, and increased frequency and severity of symptoms in asthmatic children. It is important for children aged zero to five to be born and develop in a household and an environment that does not compromise their potential with the presence of tobacco smoke.

Objectives for Consideration

- Reduce cigarette smoking among pregnant women.
- Increase smoking cessation during pregnancy, so that women who are cigarette smokers at the time they become pregnant quit smoking early in the pregnancy and maintain abstinence for the remainder of their pregnancy, following delivery and
- through postpartum.
- Increase smoking cessation by new mothers.
- Increase the proportion of providers advising smoking cessation for pregnant women and new mothers.
- Increase the proportion of pediatricians and family physicians that inquire about secondhand smoke exposure in the home and advise a reduction in secondhand smoke exposure for the patient and the family.

Strategies and/or Planning Considerations

- Promote clinician advice, assistance and follow-up for counseling and cessation services for pregnant women.
- Expand access to individual and group counseling.
- Establish or utilize smoking cessation telephone hotlines/help-lines.
- Educate about and promote the importance of clean indoor air in homes and vehicles with pregnant women and young children.
- Promote community awareness through public education campaigns about the consequences of tobacco use.
- Provide technical assistance, education and training to social service/caseworkers to screen, assess and provide referral to cessation treatment programs.
- Provide technical assistance, education and training for local health agencies and other community-based programs serving pregnant women and their families.
- Develop educational materials/programs provided to parents through child care centers and preschools.
- Support programs to prevent smoking initiation, minors' access to tobacco and exposure to environmental tobacco smoke.

INJURY/VIOLENCE PREVENTION

Background

Unintentional injury is the leading cause of death among children ages 14 and under in the United States, including drowning, motor vehicle accidents, fire-related deaths and poisonings. Each year, thousands of children under the age of 14 die from unintentional injuries. Tens of thousands more are permanently disabled each year as a result of unintentional injury. Research estimates that as many as 90 percent of unintentional injuries are preventable.

In general, poor children are disproportionately affected by unintentional injuries. Poor children are more likely to live in hazardous environments which increase the risk of injury, including substandard and overcrowded housing and proximity to busy streets, and live in homes less likely to have safety-devices. They are also less likely to have safe recreational facilities.

For children ages one to four, drowning is the leading cause of unintentional injury-related death, followed by motor vehicle occupant injury and fire and burns. In addition, suffocation is a leading cause of death among infants. Homes are the most likely site for these injuries. For example, the majority of drownings of young children occur in residential pools and two-thirds of all fire-related deaths and injuries among children under five occur in homes without working smoke alarms.

In California, firearms have surpassed motor vehicle accidents as the leading cause of all injury-related deaths. While the number of children under five years who die from

firearms-related injuries is relatively small, these children can be greatly affected by the loss or disability of a parent due to gun-related injuries. More than half of all firearms-related deaths in California occur among people aged 15 to 34. Eighty-five percent of California's births occur within this same population group.

Additionally, thousands of children each year are harmed by their parents or guardians, leading to physical and emotional injury and death. Moreover, domestic violence is the leading cause of injury to women, causing more injuries than mugging, stranger rape and car accidents combined. An estimated four million women are physically abused by their spouse or live-in partner each year.

Objectives for Consideration

- Reduce injuries and deaths resulting from motor vehicle accidents.
- Increase the use of safety belts and child restraints in motor vehicles.
- Reduce residential fire deaths of children aged zero to five.
- Increase the presence of functional smoke alarms on each habitable floor of all residential dwellings.
- Reduce nonfatal and fatal poisonings of children aged zero to five.
- Reduce injuries and death of children aged zero to five due to firearms.
- Reduce the number of children aged zero to five living in homes with firearms that are loaded and unlocked.
- Reduce drowning deaths among children age aged zero to five.
- Reduce the incidence of maltreatment of children age five and younger.
- Increase delivery of injury prevention counseling by health care and dental providers.

Strategies and/or Planning Considerations

- Increase the availability of affordable child car seats and expand training for parents.
- Support enforcement of safety belt and child restraint use – the most effective means of reducing risk of death and injury for people involved in a motor vehicle accident.
- Provide education and training to parents on the importance of installing residential smoke alarms.
- Develop a collaborative program between local fire departments and businesses to provide free or discounted residential smoke alarms to low-income families with small children.
- Provide free trigger locking devices through community groups, safety fairs, etc.

- Encourage physicians and social service providers to provide educational materials and resources to help parents evaluate potential safety risks in and around the home.
- Provide early elementary, preschool and day care center safety fairs for parents and children.
- Encourage and support community violence prevention programs for children and families.

MENTAL HEALTH

Background

Children are not immune to mental illnesses. At least one in five children and adolescents may have a diagnosable mental, emotional or behavioral problem ranging from attention deficit disorder and depression to bipolar disorder and schizophrenia. Yet approximately two-thirds of all young people with mental health problems do not receive treatment. Research shows that children whose mental or emotional disorders go unrecognized or untreated are at greater risk for school failure and dropout, drug use, HIV transmission and other difficulties, and that depression, if untreated, can result in suicide. Children experiencing mental health problems are often withdrawn, anxious or depressed, show aggressive and delinquent behaviors, attention and thought disorders, social problems and difficulty sleeping.

The term “infant mental health” currently is being used to refer to the broad spectrum of social and emotional development, and to interventions designed to support that development. The spectrum of infant mental health intervention includes:

- The promotion of positive parent-infant relationships;
- Preventive intervention with at-risk relationships; and
- Intensive intervention, or treatment, for relationship disturbances.

Parents typically seek care for their children from a primary care provider. It is therefore important for primary care providers to assess the mental health conditions of children and their parents when children have an office visit, and take on a screening and referral role. If the primary care provider screens for mental disorder in children and caregivers during routine early childhood visits, and makes referrals when treatment is needed, risk to children can be mitigated. Overall, researchers and clinicians agree that coordinated systems of care that link agencies serving children, including schools and preschools, health care and mental health providers, and community-based programs in support of children, are effective in addressing the mental health needs of children.

For Medi-Cal eligible children, the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program provides important flexibility to provide health care services that address the developmental and mental health needs of children. Yet few children to date have taken advantage of the broader range of services available. California’s Healthy Families program offers coverage consistent with that offered to state employees. While coverage covers important inpatient and outpatient services, it is not as flexible or extensive as coverage available under EPSDT.

For children covered by employer-sponsored health coverage and private health insurance, a variety of limits on benefits are typically included. Limits on mental health benefits provided in these plans typically include limits on the number of inpatient and outpatient services, co-insurances, co-payments or deductibles which are greater than that of other physical health benefits, and lower overall coverage limits. Moreover, a recent study found the amount of health insurance premium dedicated to behavioral health benefits in standard health insurance coverage is declining, from 6.1 percent in 1988 to 3.0 percent in 1997.

Objectives for Consideration

- Increase the percentage of primary care providers who are trained to screen for mental health problems for infants, toddlers, preschool children, school-aged children and adults.
- Increase the percentage of primary care providers who are trained to offer information and make referrals for parent training that focus on the mental health needs of infants, toddlers and preschoolers.
- Increase the proportion of primary care providers for children who include assessment of cognitive, emotional and parent/child functioning with appropriate counseling, referral and follow-up.
- Decrease the proportion of children who do not receive mental health care because their family cannot afford it.
- Decrease the proportion of parents of young children who do not receive mental health care because they cannot afford it.

Strategies and/or Planning Considerations

- Educate health care providers about identifying possible mental health conditions among parents and children and making referrals to mental health care providers.
- Provide regular screenings for mental health risk factors, including assessment of mental health status at every health care visit.
- Train parents and other caregivers about signs of mental health problems and/or learning disabilities.
- Link mental health referrals and treatment programs to programs like WIC and Head Start.
- Increase access to counseling and support groups for children with mental health problems and their families.
- Coordinate mental health, physical health, education and child welfare services.
- Tailor mental health treatment programs to children.
- Conduct community campaigns about mental health.
- Assure that children and parents eligible for Medi-Cal are aware of services available in the Early and Periodic Screening Diagnosis

and Treatment (EPSDT) in order to promote access to necessary developmental and mental health services.

- Link with local children's "systems of care" which serve children with severe emotional disturbances.
- Improve coordination between health plans and mental health programs to assure appropriate identification and treatment of depression and other serious mental health problems in parents and children.

REFERENCES

Introduction

California Department of Health Services, Medi-Cal Managed Care All Plan Letter 99-005.

American Academy of Pediatrics, Committee on Children with Disabilities. 1993. Pediatric Services for Infants and Children with Special Health Care Needs. *Pediatrics* 92 (1): 163-165.

Capute, Arnold J. and Pasquale J. Accardo. 1991. *Developmental Disabilities in Infancy and Childhood*. Baltimore: Paul H. Brookes Publishing Co., Inc.

California Child Care Resource and Referral Network. The 1999 California Child Care Portfolio, Final Report Pending.

Children's Defense Fund. Children in the States: 1998 data: California. April 28, 1998. Obtained online at http://www.childrensdefense.org/states/data_ca.html.

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 10-3 through 10-21. September 28, 1998.

Thompson, R.S., Taplin, S.H., McAfee, T.A., et al. 1995. Primary and Secondary Prevention Services in Clinical Practice: Twenty Years Experiences in Development, Implementation and Evaluation. JAMA 273: 1130-1135.

Schauffler, H.H. and Brown, E.R. The State of Health Insurance in California, 1998. Berkeley: University of California Press, 1999.

Maternal, Infant and Child Health

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 12-10 through 12-32. September 28, 1998.

Environmental Health

U.S. Department of Health and Human Services. Healthy People 2010

Objectives: Draft for Public Comment. Sections 5-3 through 5-4 and 5-13 through 5-19. September 28, 1998.

United States Environmental Protection Agency. *Child Health Champion Resource Guide*. Washington DC: August 1998.

California Department of Health Services. Lead Hazards in California's Public Elementary Schools and Child Care Facilities. Sacramento: 1998.

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 22-9, 22-12, 22-23, 22-24, 22-28. September 28, 1998.

Childhood Immunizations

Immunizing America's Children: Strategies and Partnerships to Remove the Barriers to Immunization. A Report from the Children's Action Network National Immunization Campaign, 1995.

CDC. Standards for Pediatric Immunization Practices. MMWR 1993; 42 (RR-5); 001.

National Vaccine Advisory Committee. The measles epidemic: the problems, barriers and recommendations. JAMA 1991; 266: 1547-52.

Good Nutrition

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 2-9 through 2-23. September 28, 1998.

National Center for Education in Maternal and Child Health. (1991) Second Follow-up Report: The Surgeon General's Workshop on Breastfeeding and Human Lactation. Washington: U.S. Department of Health and Human Services, 1991.

Nutrition Policy and Legislative News: Hunger Action Alert. California Food Policy Advocates, July 22, 1999. http://www.cfpa.net/newsletters/July99%20HAA.htm.

Richard Frye, Ph.D., Nutrition intervention improves perinatal outcomes. The Health Care News Server. January 1998. http://www.healthcarenewsserver.com/

Physical Activity and Fitness

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 1-4 through 1-5 and 1-18 through 1-19. September 15, 1998.

Pate, R.R.; et al. Tracking of Physical Activity in Young Children. *Medicine and Science in Sports and Exercise* 28:92-96, 1996.

Oral Health

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 9-4 through 9-18. September 15, 1998.

The Dental Health Foundation. *The Oral Health of California's Children: A Neglected Epidemic*. San Rafael: The Dental Health Foundation, 1997. "Oral Health Disparity for Low-Income Children." Children's Defense Fund. Child Health Information Project Listserv, June 30, 1999.

Alcohol and Other Drug Use

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 12-25. September 28, 1998.

Freeman, J., Prenatal and Perinatal Factors Associated with Brain Disorders. (NIH Publication No. 85-1149). Washington: U.S. Department of Health and Human Services, 1985.

No Safe Haven: Children of Substance-Abusing Parents, The National Center on Addiction and Substance Abuse at Columbia University, January 1999.

U.S. Department of Health and Human Services, Eighth Special Report to U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services, September 1993.

U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert #13, July 1991.

U.S. Department of Health and Human Services, National Institute on Drug Abuse, Drug Abuse and Pregnancy, Capsule #33, June 1989.

U.S. Department of Health and Human Services, Center for Substance Abuse Prevention, Alcohol, Tobacco, and Other Drugs May Harm the Unborn, reprinted 1994.

Tobacco Use

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 3-9 through 3-14. September 28, 1998.

U.S. Department of Health and Human Services, Center for Substance Abuse Prevention, Alcohol, Tobacco, and Other Drugs May Harm the Unborn, reprinted 1994.

U.S. Department of Health and Human Services, National Institutes of Health, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders, 1993.

U.S. Department of Health and Human Services, National Institutes of Health, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders, The Report of the U.S. Environmental Protection Agency, 1993.

Injury/Violence Protection

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 7-4 through 7-23. September 28, 1998.

SAFE KIDS Campaign. Children at Risk Fact Sheet. December 1998.

SAFE KIDS Campaign. Childhood Injury Fact Sheet. December 1998.

Centers for Disease Control and Prevention. Firearm-Associated Deaths and Hospitalizations – California, 1995-1996. *MMWR* (June 18, 1999) 48(23): 485-488.

California Death and Birth Records, 1997. California Department of Health Services, Center for Health Statistics. Online Vital Statistics Query System: http://www.dhs.cahwnet.gov/

Centers for Disease Control and Prevention. National Center for Health Statistics. *National Vital Statistics Report*, November 10, 1998. 47 (9).

Pacific Center for Violence Prevention. Selected Recommendations for Injury and Violence Prevention in California. September, 1996. Website: http://www.pcvp.org/violence/other/recom4.html.

U.S. Department of Health and Human Services, Health Resources and Service Administration. *Models That Work Compendium, 1998. Best Practices in Women's Health Domestic Violence*. American Association of Health Plans, 1998. http://www.aahp.org.

Mental Health

U.S. Department of Health and Human Services. Healthy People 2010 Objectives: Draft for Public Comment. Sections 23-4 through 23-15. September 15, 1998.

Children's Defense Fund, Meeting Children's Unique Mental Health Needs, obtained online March 26, 1998 at www.childrensdefense.org/health_mentalhealth.html.

The Hay Group. Health Care Plan Design and Cost Trends – 1988 through 1997. May 1998.

Skin Cancer Prevention

Department of Health Services, Skin Cancer Prevention Program
P.O. Box 942732, MS-622
Sacramento, CA 94234-7320
amanthe@dhs.ca.gov

ATTACHMENT A

Operational Plan for the Principles on Equity

to Sustain and Strengthen Cultural and Linguistic Diversity of First 5 Policies and Programs

JUNE 2006

INTRODUCTION

First 5 California operates under a set of Guiding Principles and a set of Principles on Equity that, taken as a whole, provide an operational framework for the creation and implementation of First 5 California programs and initiatives.[1]

The Principles on Equity were adopted by the State Commission in 2001 in direct response to the needs of the State's diverse child population and to address "significant gaps and disparities in the provision of services for children and their families; and to inform and guide policy and funding decisions." The objectives of the First 5 Principles on Equity are to:

- Ensure that the perspective and needs of diverse populations and communities are reflected in First 5 California's priorities, policies and practices;
- Promote culturally competent and linguistically appropriate programs; and
- Actively engage families in these efforts.

For First 5, diversity has been defined to be inclusive of children, prenatal to five years of age, regardless of immigration status, who:

- Are from different ethnic, linguistic, cultural, socio-economic, religious, geographical and/or other historically or currently under-served communities; or
- Have disabilities and other special needs.

In 2004, First 5 California initiated the Special Needs Project, a $20 million investment, to specifically address the needs of children with disabilities and other special needs. The Special Needs Project has 10 demonstration projects that operate as a part of the School Readiness Program. The State Commission in that same year also authorized a Diversity and Equity Project to assess the impact of the Principles on Equity, particularly pertaining to issues of culture, ethnicity, language, socio-economics and other diversity factors. The Diversity and Equity Project commenced its work in 2005 by conducting surveys, interviews and meetings with First 5 leaders and partners throughout the state and by reviewing a variety of First 5 reports and data. This assessment formed the basis of this Operational Plan. The goal of the Operational Plan is to achieve better outcomes for all children by sustaining and strengthening the cultural and

[1] Strategic Plan for 2003 – 2006, page 4.

linguistic diversity of First 5 services through quality enhancements and needed policy and program improvements.

The Operational Plan:

- ***Identifies statewide priority areas for State and County Commission efforts;***
- ***Provides additional guidance and resources to help State and County Commissions establish short- and long-term goals to improve the diversity and competency of its programs and services; and***
- ***Recommends corresponding strategies to strengthen organizational diversity and equity practices.***

This Operational Plan was developed with the guidance and leadership provided by the Diversity and Equity (D&E) Steering Team and with input from hundreds of First 5 stakeholders. The D&E Project Steering Team is comprised of representatives of State and County Commissions, the First 5 Association, the Advisory Committee on Diversity and outside experts. This Plan represents a starting point for a collaborative agenda, which will evolve over the next five years.

Why an Operational Plan?

- A significant proportion of culturally and linguistically diverse children, including children with disabilities and other special needs, and their families continue to be among the most vulnerable and the most in need of culturally competent and linguistically appropriate services, including developmental screenings, assessments and early intervention.
- State and County Commissions share a commitment to addressing disparities and access issues. Many of the current State and County First 5 investments and priorities specifically address diverse child population groups (e.g., School Readiness, Special Needs Project, Health Access for All Children).
- The State Commission strives to have a more structured process and strategies in place toward implementing the First 5 Principles on Equity and in holding itself and its partners accountable for more specific results in reducing disparities.
- Large and small local commissions, both in urban and rural parts of the State, have asked for practical suggestions, tools and resources to help engage families especially those most in need of First 5's efforts.
- State and County Commissions can have a greater impact in some priority areas.
- Improvements in these areas will require collaboration among State and County Commissions.

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

VISION STATEMENT

California children from diverse backgrounds and with different abilities - and their families - are an integral part of the planning and implementation of First 5 policies, programs and services.

- Children and their families must have access to high quality and culturally competent early care and education/development opportunities.
- Agencies are accountable for compliance with laws and regulations pertaining to the provision of services to children from diverse backgrounds and with diverse abilities.
- First 5 funded programs are well defined and have meaningful outcomes that benefit these populations.

Equity principles are infused in everything we do.

- First 5 reaches out to the most needy children through our programs and services.
- First 5 programs and services are family centered and actively engage parents and other community members in the planning and implementation of its programs and services.
- First 5 builds nontraditional partnerships in communities and across the state.
- First 5 uses funding mechanisms that have a differential impact on need.
- First 5 provides available resources for the implementation of culturally competent and linguistically appropriate strategies in all statewide initiatives and programs.
- First 5 supports professional and workforce development needed to ensure that it can offer quality programs and services that are developmentally, culturally and linguistically appropriate.

The work that is currently under way at both the State and County levels should be honored and acknowledged because State and County Commissions have:

- ***A rich history of accomplishments, effective partnerships and highly successful program models on which to build and learn from these efforts;***
- ***Adopted a variety of promising practices for building leadership, the workforce and organizations serving young children and their families; and***
- ***A shared sense of commitment to address service disparities and to improve the quality of care of our youngest children throughout the state.***

RECOMMENDED PRIORITY AREAS

A Diversity and Equity Steering Team composed of State and County Commission representatives, members of the Advisory Committee on Diversity and outside experts identified the priority areas to address the most pressing gaps in diversity and equity practices. County Commission leaders and other First 5 stakeholders affirmed these priorities through a series of dialogues coordinated with the First 5 Association, in regional meetings and in First 5 Conference workshops. In general, most Executive Directors and Commissioners providing feedback agreed that the priority areas are consistent with the values of their commissions, and in many cases, reflect the work they are already doing.

These priority areas represent a vehicle for further expanding, strengthening and accelerating these efforts to achieve better results for all children.

The priority areas are organized as *two overarching goals* ***and*** *five priority areas.* ***Two of the priorities – "early literacy and language", and "sustaining the service infrastructure for young children and their families" -- are identified as key areas for collaborative action beginning in 2007. The remaining priority areas are also critical to diversity and equity practices but are not ranked in any specific order for implementation. For each priority area, State and County Commissions – informed by their respective strategic plans – may choose to develop a specific Action Plans to strengthen their work with their respective partners and stakeholders. In the spirit of partnership, the State and County First 5 leaders should work together to maximize their efforts.***

GOAL 1

Reduce disparities in access to services and outcomes for children, with a focus on ethnicity, income and special needs by ensuring that First 5 initiatives and programs respond effectively to the needs of children and their families who face greater challenges in their preparation to succeed in school.

GOAL 2

Support the continued infusion and integration of diversity and equity values into the culture and practice of First 5 commissions, programs, initiatives and leadership.

TOP 2 PRIORITY AREAS (Examples are provided for illustrative purposes only)	
A. Strengthen the early literacy and language skills of all young children to ensure a strong foundation for English acquisition and reading success. For example: ▪ Build stronger awareness and leadership to assess and address developmental needs (including language development, health, etc.) of young English language learners and their families among First 5 Commissions, their grantees and other partners. ▪ Identify and respond to gaps in literacy and language acquisition among groups of children whose home language is English. ▪ Create a strong foundation for literacy and language (English acquisition) to address the specific needs of children of immigrant parents. ▪ Promote the use of program designs, curriculum, and tools that honors and	**B. Strengthen the capacity and sustainability of the service infrastructure for young children and their families in resource-poor communities, neighborhoods, organizations and programs.** r example: ▪ Invest human and financial resources in building the capacity of emerging grass-roots organizations and in enhancing the capacity of existing community-based organizations to participate in First 5 efforts (e.g., grantmaking, data collection, proposal writing, negotiating contracts). ▪ Build the capacity of Commissions and providers to sustain and fully integrate programs and strategies (e.g., promotora model) to better serve populations not assisted by traditional institutions and outreach methods. ▪ Develop and disseminate an Organizational Diversity Practices Toolkit -

strengthens the home language of young English learners and their fluency with other cultures in all First 5 funded programs and initiatives ▪ Utilize all opportunities to support young English learners in a variety of settings including early education, social services and health (e.g., Reach Out and Read).	based on best practices among State and County Commissions and other partners. ▪ Provide leadership and invest resources and time to establish inclusive community partnerships that set direction for commission grant-making decisions. Shift from a competitive funding system to a collaborative, inclusive one. ▪ Improve access to services by investing resources to develop and disseminate education tools and materials in various languages and at appropriate literacy levels.

OTHER PRIORITY AREAS:

- **Work to ensure that all 5 year-olds have a strong foundation to become successful dual language learners.**

  For example:
  - Promote the development of a second language and cultural fluency among children whose home language is English.
  - Invest in professional development for the early childhood education profession as well as recruitment and outreach to bilingual educators.

- **Provide technical assistance to help County Commissions select and collect appropriate information and use disaggregated data reports effectively to better inform their decision making when addressing the challenges faced by different subpopulations/groups.**

  For example:
  - Incorporate information into training workshops at the state and regional level that will assist commissioners and staff to better analyze data to increase their understanding and ability to determine appropriate responses to the needs of hard-to-reach and underserved populations.
  - Collect and disseminate information on practical evaluation approaches and tools that State and County Commissions and their partners (including key private and public entities) could use to identify gaps in services for different groups of children.

- **Conduct and disseminate policy research that highlights disparities that most impact children from diverse backgrounds and advocate for improvements in public systems and policy solutions to close gaps in services and funding.**

  For example:
  - Include information and data in policy research about workforce issues concerning communities that face the greatest shortage of qualified early childhood educators; and work to ensure that First 5 equity values and practices are embedded into the training that is provided.
  - Invest resources in technical assistance and training related to cultural

competency and special needs for commissioners, commission staff, contractors/grantees and other partners.

The State and County Commissions can develop a specific Action Plans for each selected priority area; the Action Planes will outline the work and the resources needed to achieve the outcomes and results desired.

Strategic Approaches

To guide the development of Action Planes and to measure progress towards "bridging the equity gaps" in each strategy, the use of three crosscutting approaches are proposed:

- **Build on current strengths** -- First 5 leaders have lead the way in addressing diversity and equity in key areas outlined in the *Principles on Equity.* Once their innovative and effective strategies are identified, they should serve as the foundation for expanding the knowledge-base and skill set of the entire First 5 community and their partners.

- **Support bold leadership among commissioners, staff, partners and grantees --** Passionate and knowledgeable leaders at the state and local level propel meaningful action on equity and diversity issues. It is critical to the success of First 5 that it develops and nurtures leaders willing to be proactive in promoting new and promising approaches to sustain and strengthen the cultural and linguistic diversity of First 5 programs and policies and to integrate the principles and values of equity.

- **Build sustainable capacity within the system --** Success in this work requires a deliberate investment of resources in training, technical assistance and data resources to build capacity, including workforce and professional development, parent and community engagement, etc. Further it is essential to have the capacity to collect, understand and use disaggregated data to give a clearer picture of the challenges facing different population groups to help Commissions evaluate their own performance and effectiveness, to be more accountable, and to disseminate effective outcome-based approaches and strategies.

These approaches are interrelated and emphasize best practices. These approaches should also guide decisions on how to measure progress towards bridging the equity gaps in each priority area.

These three strategic approaches will provide the framework for the Action Plans to be developed for each of the priority areas. These Action Plans, at a minimum, will identify major activities, leads and partners, targeted First 5 programs, timeframe, outcomes/results and needed resources. Over the course of the next few months, Action Plans for the two top priority areas will be developed with input from the County Commissions and other partners. It is anticipated that the Action Plans will be presented to the State Commission in late 2006.

ROLES AND ACCOUNTABILITY

Given the complex nature of communities and the size and diversity of the First 5 target population in California, no single group, sector or organization alone can achieve the policy and program improvements needed to achieve better

outcomes for young children from diverse backgrounds and with diverse abilities.

This Operational Plan assumes that the responsibility for improving results for these children is a shared obligation; one that requires continuing efforts to improve communication, share information, and enhance the training and support of key stakeholders. The collective responsibility of all groups is to adhere to the First 5 Principles on Equity or similar value statements. At the same time, commissioners, commission staff, contractors, public agencies, early childhood educators and providers, families and caregivers, teachers and administrators, policy makers, advocates and other key stakeholders have specific roles and responsibilities with corresponding accountability.

Outcomes-based accountability -- *achieving desired outcomes as opposed to measuring services delivered* – will be essential in reviewing the progress of State and County Action Plans. Consistent data collection and analysis of information for use in decision-making and performance evaluation will also be critical to success. Evaluation strategies (at various levels: commission, system and individual) should link to other statewide initiatives such as the Special Needs Project, Health Access for All Children, School Readiness, Power of Preschool Demonstration Projects, etc.

STRUCTURE AND RESOURCES

Once this Operational Plan is adopted, specific Action Plans for one or more of the goals and priority areas can be developed and adopted by the State and County Commissions. Adequate resources and a coordinating structure will be needed for implementation including administration, human resources, communication, monitoring and reporting.

In July 2000, the State Commissioners established the Advisory Committee on Diversity to serve as their policy advisors on issues related to diversity and equity. The Committee was responsible for the development of the Principles on Equity adopted by the Commission in 2001. The Committee played a valuable and key role in formulating many of the State Commission's initial programs and initiatives, ensuring that diversity and equity were cornerstones of the early work.

In light of the new priority areas and the structure required to implement them, it is necessary to assess the function and form of the Advisory Committee on Diversity. The question of its continuing role was discussed in telephone interviews with several Advisory Committee members, First 5 California staff, Executive Directors of County Commissions with similar advisory groups, and the Director of the First 5 Association of California. County leaders were also asked for feedback on this issue during four regional feedback sessions. State Commissioners Walker-Duff and Vismara, co-chairs of the Commission's Subcommittee on Equity Principles, were also consulted on this matter and they provided feedback on the proposed new committee structure.

There was general agreement that the Advisory Committee on Diversity played an important role in how State programs developed in the early years of the Commission but that, as a group, it was not set up to address implementation of the Principles on Equity. Most respondents believe that an advisory body to the State Commission remains important to assist in the future work of First 5 California and that such a group must be well integrated into the vision and priorities of the State Commission.

<u>Proposed Structure</u>

There is strong support among interviewees and County leaders for the following recommendations:

1. **The Advisory Committee on Diversity be acknowledged and thanked for their foundational work in the development and adoption of the Equity Principles and that the Committee be dissolved.**

2. **A Diversity Steering Committee will be created to support the Operational Plan. The Steering Committee would be the counterpart of the Input Group overseeing the Special Needs Project. The two groups would collaborate and coordinate their efforts. The joint meeting of the two groups will comprise the Commission's Subcommittee on Equity Principles. The Subcommittee on Equity Principles will meet at least annually.**

3. **The Steering Committee will serve as an advisory body to the State Commission, making recommendations on improving the policy and program practices of First 5 California in better addressing matters related to diversity and equity (e.g., ethnicity, cultural, language, socio-economics, geography, etc.).**

   Committee members should have specific expertise and a statewide perspective to assist both the State and County Commissions in this work.

   To establish this Committee in early 2007, it is further recommended that:

   a. The Diversity and Equity Project and their Steering Team work with State Commission staff to develop a profile of the expertise and constituencies to be represented on the Committee (both practitioners, content experts, representatives from other First 5 initiatives*)* and the process and timeline necessary to identify them.

   b. State Commissioners would nominate non-County Commission members for the Steering Committee.

   c. The County Commission representatives (Executive Directors or staff) to the Committee would be nominated by each of the First 5 Regions.

   d. The appointments made by the State Commission are for 3-year terms; and that the first appointments be staggered (50% for 2-year terms and 50% for 3-year terms) to ensure continuity on the Committee. It is assumed that members are eligible for re-appointment upon the successful completion of their term.

4. **The Diversity Steering Committee will be charged by the State Commission to oversee the implementation of this Operational Plan, and be responsible for developing appropriate mechanisms to identify successes in achieving the goals of the Plan.**

   For example, the Committee would assist in the implementation of the Operational Plan by:

   a. Coordinating "Implementation Teams" for the priority areas of First 5 California. An Implementation Team, a small collaborative group, would be organized around a priority area to set objectives, timelines and measures for success;

   b. Coordinating with the Special Needs Project Input Group and with other existing First 5 Initiative groups (e.g., School Readiness, Power of Preschool) to address and improve different aspects of their programs including cultural competency,

linguistic appropriateness, accessibility, inclusive governance and other related issues;

c. Working with the Evaluation Workgroup on First 5 efforts around data collection and the use of data reports;

d. Providing expert consultation to new initiatives;

e. Helping State Commission and First 5 Association staff expand the quality of First 5 programs and services by identifying best practices and resources including training and technical assistance providers;

f. Assisting County Commissions in developing Action Plans, and/or serving as a resource to a local Commission or First 5 region (e.g., convening workshops around best practices, coordinating "expert panels" on specific issues related to cultural competency, linguistic appropriateness or other diversity issues); and

g. Developing mechanisms to monitor the achievement of the Plan's goals.

5. The First 5 California Commission, in collaboration with County Commissions and the assistance of the Diversity Steering Committee, will establish a process to update the Plan as it evolves over the next 5 years.

Fiscal Resources *(To be completed upon the development of specific Action Plans to be presented to the State Commission by January 2007)*

Financial resources are needed to support full implementation of the Operational Plan and resulting Action Plans. Effective and realistic fiscal strategies and technical assistance will be required to support this work which is integral to the successful implementation of First 5 programs. The Operational Plan and initial Priority Areas provide a framework for revising project budgets or developing new budget proposals. Resources may include leveraged funds or redirected funds. In some cases, new revenue may be required.

- Additional staffing will be needed to ensure the implementation of the Operational Plan and to support the Diversity Steering Committee. This staff person – and the Committee – may require the support of external consultants as needed.

- Upon completion of the Action Plans, additional details will be provided for this section on Fiscal Resources which will include:

    - The resources required for each Priority Areas selected (e.g. costs for facilitators, curriculum development, trainings, technical assistance).

    - Opportunities to leverage or match revenue between State and County Commissions or with other private, local, state or federal programs.

    - Current and future First 5 investments - scope, purpose, term - and opportunities to enhance the infusion of diversity and equity values in their implementation.

ACKNOWLEDGMENTS

Diversity and Equity Project Steering Team

State Staff	**Kris Perry, Emily Nahat, Patricia Skelton, Barbara Marquez**
County Commission Executive Directors	**Brenda Blasingame, Sean Casey (Contra Costa)** **Evelyn Martinez (Los Angeles)** **Pedro Paz (Merced)** **Francine Rodd (Monterey)** **Steve Thaxton (El Dorado)**
Advisory Committee on Diversity Members	**Carlene Davis, Lupe Alonzo-Diaz, Whit Hayslip, Pat Phipps, Maysee Yang**
First 5 Association	**Sherry Novick**
Community At-Large Members	Corrine Hicks, Christina Rodriquez de la Mar, Rafael Gonzalez

Diversity and Equity Project

California Tomorrow ***Oakland***	Ruben Lizardo (Project Director), Laurie Olsen, Cecilia M. Sandoval, Alan Watahara
Interaction Institute for Social Change *San Francisco*	Pat Bruce-Lerrigo, Bruce A. Truitt
Consulting By Design Fresno	*Felicia Batts*
Subject Matter Consultants	Julie Olsen-Edwards, Marci Hanson, Intisar Shareef

We thank the hundreds of individuals who participated in this process and helped in the development of this Operational Plan by sharing their knowledge, advice and perspectives. In addition to Steering Team meetings, individuals participated in telephone interviews, First 5 Association meetings and workshops, regional meetings, conference calls and statewide conference roundtables and panels. We appreciate the assistance provided by the Executive Directors who serve as Regional Liaisons for setting up meetings or conference calls during May 2006 to discuss the Operational Plan. We thank all of participants for their pertinent recommendations, as well as individuals who made suggestions for and reviewed drafts of this document, most notably Emily Nahat and Barbara Marquez on staff at First 5 California.